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—N. M. Dodson, M. D., President's Address, 1884.

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Mistakes in General Practice*

By H. V. FOSHION, M. D.
Algoma

Perfection is an ideal which is never attained, but which is approached in two ways; first, by repeating those procedures which have led to a successful result, and second, by avoiding those procedures which have led to an unsuccessful result. The latter is simply another way of saying "avoiding mistakes". And here by mistakes I do not mean something which is wrong in itself, but some procedure which has led to an unsuccessful result in spite of the best intentions that it should lead to a successful one. In the same sense, a mistake as here spoken of does not mean that the one who made it is in the least an incapable physician, but that like all other human beings he is not infallible. As Huxley said, "The people, scientific or other, who never make mistakes are those who do nothing."

We are guided in the choice of our methods of procedure not only by our own experience, but by the accumulated experience of others. Someone has stated this fact tersely in these words, "Fools learn by experience, but the wise by the experience of others."

In the field of medicine we nave an enormous amount of recorded experience of others, but it is almost entirely of the first type which I mentioned, that which has led to successful results, and not infrequently the successfulness is somewhat exaggerated. The bad results and the failures are almost never brought to the attention of our fellow practitioners. That is where I think we neglect an important factor which would be very helpful to our profession. We should, at times, stop to consider our sources of error and causes of failure, not only individually but in groups. The value to us would be greater in the same proportion that group experience is greater than individual experience. As one of my professional friends Dr. W. M. Wochos has mentioned several times at our local meetings, "We would get much more out of our monthly meetings if we devoted one or two a year to a frank discussion of our mistakes."

There is another advantage in this idea of a discussion of mistakes. Whenever I start to write a paper I soon find myself suffering from a very common ailment known as a "shortage of ideas". For the benefit of any of you who have the same affliction let me say that if you want to write about your mistakes you will have no trouble writing a lengthy paper, one which will take up the entire evening meeting.

I mentioned the tendency we all have of giving prominence to successful results and of keeping other results in the background. I might make this a little clearer by taking, as an example, articles which we see frequently on the treatment of malignancies with radium. The successful results and the percentages of cures are vividly pictured with photographs of cases before and after treatment showing the good cosmetic results, etc. Near the end of the article there may or may not be a sentence or two stating that one of the disadvantages of radium is the possibility of infection. However, there are no case histories or photographs of the patients who died as the result of infection following radium treatment—those are left out entirely. Altogether, we are inspired by the articles and impressed with the efficacy of radium as a therapeutic agent, but the danger of fatal infection from its use does not register in our minds at all—until we get a case of it ourselves.

I do not mention this as a criticism of the men writing those articles or any other articles, but simply to illustrate the tendency of

* Presented before 89th Anniversary Meeting, State Medical Society of Wisconsin, Milwaukee, Sept. 1930.

all of us to magnify and dwell upon our good results and to forget our bad ones or to reduce their prominence to a minimum.

ERRORS OF OMISSION

The largest group of errors we, as general practitioners, make are no doubt so called errors of omission. Relative to diagnosis, for example, we may make the mistake of not getting a complete and careful history, or may omit a part of the physical examination or omit an important special examination, such as a leucocyte count or gastric analysis. The cause of the omission may be one of the following:

1. The symptoms may be all local and apparently due to an involvement of only one organ or part of the body. Thus they mislead one into thinking that a general examination is not necessary for the correct diagnosis.

However, one must remember that symptoms in one organ may be the result of trouble in some other part of the body remote from it. For example, the cause of anorexia may be a diseased stomach, gall stones, appendicitis, a partial bowel obstruction, pulmonary tuberculosis, a chronically infected sinus, the onset of a general systemic infection or what not. Another case complaining only of pimples may have diabetes as the cause. To omit a thorough history and physical examination in such cases is a mistake which may be serious.

2. A second factor which may lead to an error of omission is that the patient's complaints are vague, indefinite, or obscure. The fact that the patient's complaints *are* vague, indefinite or obscure is the very best indication for a complete *systematic* history and physical examination. The only way to arrive at the correct conclusion or anywhere near the correct conclusion in a case like that is first to get a good history by getting the patient to talk. The best way to do that is to lead the patient with a series of questions designed to bring out symptoms referable to the different systems of the body, preferably beginning with general symptoms first, such as lack of energy, sleep, loss of weight, etc.; then following that according to some plan such as head and neck, cardio-respiratory system, gastro-intestinal, genito-urinary, neuro-muscular, etc. By getting patients to talk in that way one often gets some very valuable information not obtainable in any other way. They will sometimes indirectly give information which they previously denied in answer to a direct question. For instance, you may ask a patient if she is constipated and she says "No". Then you get her to talk about her stomach, or bowels by following some such plan as I mentioned, and she will tell you she takes a physic every day. If this sort of history is followed by a complete physical examination, the chance of overlooking something is not great. To omit either one, or any part of them is likely to lead to error.

3. A third factor which may lead to a mistake of omission is hurry. The physician may be in a hurry due to an urgent call, or because of uneven distribution of work. In that case an arrangement should always be made for further consultation at some other time rather than try to complete the consultation in a hurry, and thereby omit something important.

Frequently the *patients* are also in a hurry, not for any special reason, but because they place too little importance on matters of health. They come in for a short consultation, a quick conclusion, and a hasty prescription. There are still many people who make a medical consultation incidental to their going down town, and hurry in to the doctor for a diagnosis in between their shopping errands. It is a mistake to prescribe under these conditions and frequently a source of error.

4. Simple negligence may be a source of error and should be guarded against.

5. Errors of omission may be made because of a lack of complete knowledge of a given ailment and its protean manifestations. or because one temporarily forgets some phase of it. Medicine is such a broad field that one cannot be on his toes on every phase of it all the time. The following case cited in a clinic which I attended a short time ago illustrates this point. A patient was suffer-

ing with chronic diarrhea. The stools had been studied for presence of blood, pus, and parasites. The bowel had been studied by means of the x-rays and the sigmoidoscope. The blood had been examined. But no gastric analysis had been made by the first physician consulted, and this particular patient's diarrhea happened to be due to an achlorhydria, and promptly subsided upon administration of HCL by the second physician.

In such cases consultation with another physician or with some up to date volume on diagnosis would, no doubt, have corrected the omission. In the case mentioned, for instance, the first doctor probably knew that achlorhydria is a cause of diarrhea, but he had temporarily forgotten the fact. Just a hasty reference to a text book on diagnosis or a consultation with another physician would have refreshed his memory on this point.

UNWARRANTED CONSIDERATION

Another group of mistakes which we make can be grouped under the following heading: Too much *unwarranted* consideration for, or sympathy with, the patient or members of his family.

1. We sometimes allow ourselves to be deviated from what we believe to be the best course to follow, because the patient or his family is prejudiced in some way. I can best illustrate that by an experience I had some time ago with a case of placenta previa. I was called to a farm house at midnight and, upon arriving, found a woman about eight and one half months pregnant lying in a lake of blood. Her face was deathly pale and pulse rapid. I told the husband of the danger she was in and said I would have to pack her. A pack, I thought, would prevent further hemorrhage and probably start labor and bring about a normal delivery after sufficient time had elapsed to restore some of the blood volume. The husband objected to packing, because he knew of a woman who had been packed and died, as much as to say that packing caused death. He asked to have another physician called to which I gladly consented. While I returned to the office for some sterile material for packing the other physician arrived. He apparently did not overcome the husband's prejudice against packing, because on my return to the house he suggested that we do a version and extraction after which the danger of bleeding would be removed. This we did. The soft cervix dilated easily and the extraction was not difficult, but the cervix which naturally was very vascular due to the placenta previa bled considerably before the delivery was completed. This bleeding, added to the acute hemorrhage which the patient had had only a few hours previously, was sufficient to bring about the fatal result which occured shortly after delivery. Now I know that whenever we have a fatal result with one method of treatment we are apt to think that something else should have been done instead, but in this case I have no doubt that had further bleeding been prevented by packing, the woman taken to a hospital and given time to recuperate somewhat from the first hemorrhage, and a more gradual dilatation of the vascular cervix permitted by natural delivery, and possibly a blood transfusion given, the result would have been better. Under no condition would I allow anyone to swerve me from my own choice of treatment again, in a similar case.

2. Expense to the patient is another factor which too often comes in for too much consideration on our part. For example, if there is not a very definite indication for an x-ray examination we frequently fail to insist upon it, or even fail to advise it because we are afraid to create an expense for the patient. Yet, that same patient may go to a clinic in some larger city and spend more than it would cost him at home. Or he may go to the Mayo Clinic and spend more for transportation alone than the entire cost of his diagnosis would amount to at home, to say nothing of his hotel and other expenses, besides waiting a week for his diagnosis. We, as general practitioners, are much more prone to that mistake than anyone else, because we know the patient's economic condition and are apt to make the mistake of giving too much consideration. We, in general practice, would be much better off if we

required an x-ray examination whenever there is the slightest indication. We should consider that we are rendering the patient a service when we do so, for not infrequently the x-ray reveals something which we least expected from our physical examination. The same thing can be said of other special examinations.

The matter of expense also frequently enters into the question of hospitalization. We may decide to treat a patient at home because she cannot afford to be hospitalized. In the meantime some friends may come in and induce the patient to go to some hospital elsewhere. Only a short time ago I had such an experience. A patient of very poor means came in for examination. She happened to be suffering with a moderately severe exophthalmic goitre. She being the wife of a laboring man who was making very little money, I advised her to get someone of her relatives to do her housework, and I put her to bed under medical treatment until I could be able to determine the best time for operation. It was only a few days when these relatives of hers induced her to go to a hospital in another city. After a short rest she had her thyroid removed. This may not appear like a mistake but it was, because the fee for the thyroidectomy was not found in my accounts, but in the accounts of someone else who could have gotten along without it much better than I could.

3. Another form of sympathy which may be a mistake is that of taking too much of the family's burden upon our own shoulders in case of serious illness. For instance, we go into a home where one of the children is very sick with an illness which may prove fatal, and we feel that the parents should be told of this possibility. Yet, seeing the mother and others in the family already overburdened with anxiety over the patient's condition, we put off telling them, because there is a chance of recovery, and we do not want to increase their burden if it is possible to avoid it. By so doing we expose ourselves to criticism if the outcome happens to be a fatal one. We will not be credited with compassion for this, but charged with inability to realize the extent or seriousness of the illness.

ACCIDENTS

Lastly, there are those errors which are purely accidental which we must continually be on our guard against. Here may be mentioned the accidental administration of the wrong drug or of an overdose of some powerful drug. The late Dr. Loevenhart used to tell us when he gave his lecture in pharmacology at Wisconsin, that we should always look at the label twice before administering a drug, because once the drug is in the patient it is pretty hard to get it out. This is especially true of subcutaneous or intravenous medication.

I might mention here an accident which I had when I violated this rule of Dr. Loevenhart's. I had a patient who had a periodical hematuria for which I could find no cause. I took the patient to a urologist who discovered a small area on the bladder wall from which the bleeding came. He advised injecting a 1 to 1000 solution of silver nitrate into the bladder. I ordered the silver nitrate solution from the druggist by telephone. He did not make up the solution right away and then forgot the strength I had ordered and made a much stronger solution. He intended to tell me that he had forgotten the strength of the solution ordered, but when he brought the bottle to my office I was not in, so he left it on the table in my waiting room. I came in later for the solution and noticed the bottle there with AgNo3 written on the label but did not notice anything else. I took the bottle, went to the patient and injected three ounces of the solution into the bladder without again looking at the label. The solution was no sooner injected than the patient complained of severe bearing down pains and hurried to the toilet to pass the solution. She continued to complain of bearing down pains. I thought it queer that she should have so much pain, so I went back to look at the bottle again. I almost passed out when I noticed just around the curve of the bottle, after the AgNo3 sign which I had noticed before, a 10 per cent sign. For several days I was on needles and pins whenever I thought of that, and I thought of it most of the time. The patient passed white flakes of epithelium for several days, but got well within two weeks

and has had perfectly normal bladder function. This occurred several years ago and the patient has never had a recurrence of her hematuria. The treatment resulted in a perfect cure. However, we would not always be that lucky under such conditions.

In concluding this case history let me say that before injecting any solution subcutaneously or intravenously or into any body cavity, one should always ask himself the following questions:

Is this the right drug? Is the solution of the right strength? Is the dosage safe?

If using the medication intravenously one should always remember to inject it slowly and stop immediately should the patient experience any unusual sensation.

You might gather from what I have said this afternoon that I am somewhat of a pessimist or a grumbler, but I am not. What I have said has been with the intention that it might be of some help, at some time, to some one here.

Cooper said that, "Life is merely a series of opportunities for turning failures into successes."

If I have said anything that will help anyone of you in turning one failure into success, or help in bettering general practice in any way, I shall feel that my time has been well spent.

The Deaf Child*

By RICHARD L. BOWER, M. D.
Kansas City, Missouri

Certainly, one must have a reason for the presentation of such a trite subject as "The Deaf Child". The present generation thinks much, talks much and writes much of the right of the child to the best possible chance in life, physically and mentally, and it is a sad commentary on our knowledge of the subject that over 30% of the inmates of our institutions for the deaf are children who have an acquired deafness, which might have been prevented if taken in time.

The deaf child, naturally, has either been born deaf, or has acquired its deafness after birth. The first type, usually spoken of as congenital deafness, has in turn been divided by Goldstein into biologic congenital deafness and pathologic congenital deafness.

The biologic variety is due to some developmental defect, either in the otic capsule, in the nerve or in the brain.

Pathologic congenital deafness is the result of disease, usually of one or both of the parents, such as syphilis or tuberculosis. As a rule, in congenital deafness the child is born deaf but in a particular instance, namely, otosclerosis, deafness does not become marked until the age of puberty or later in life. This is probably the type that Anatole France had in mind when he wrote his playlet "The Man Who Married a Dumb Wife" which has to do with a husband whose wife's affliction saddened him until she was restored to speech. Then she talked so much that he was glad when he became deaf.

The second variety, acquired deafness, as has been said, appears after the child is born, within the first few months or later on in childhood during the first five years, the result of some febrile disturbance; one of the exanthems or because of certain local conditions which interfere with the delicate mechanism of the middle and inner ear. Most writers who have studied the matter carefully assert that the majority of cases are the result of neglect of the ears after measles, scarlet fever, upper respiratory infections and meningitis which may be either of the epidemic type or one of the low grade meningitides so often caused by syphilis. In fact, the whole question may be summarized thus: "Nearly all deafness is due either to infectious disease or wrong marrying".

With such a foundation we can consider, in more detail, the management of this problem of congenital deafness in children. Certainly, it behooves the medical profession as a whole to advise against consanguineous marriages. Alexander Graham Bell in an address to the deaf on marriage said: "As

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there are few families entirely free from constitutional defects of some kind, a prudent person would do well to avoid a consanguineous marriage in any case, not necessarily on account of deafness, but on account of the danger of weakening the constitution of the offspring".

Brooks says: "The intermarriage of people with deaf relatives (that is, congenitally deaf) is almost sure to result in deaf children, more than half the children being deaf whether the marriage is between deaf or hearing people".

In this question of marriage and deafness, of course, acquired deafness plays no part.

Fay in "Marriage of the Deaf in America" says: "Whatever answer may be given to this difficult question, it cannot be doubted that all persons, whether deaf or hearing, who have deaf relatives and all persons who may wish to marry individuals belonging to this class, ought to be fully informed in due season of the fact that marriages of persons having deaf relatives are liable to result in deaf offspring".

"When a man and woman plan to set up a family with a collection of handicaps as their only assets, how long will it be before they and their children sink into the terrible category of those who live only because civilization agrees that human life is sacred?"

May I not repeat that the above remarks apply to congenital deafness and not to acquired deafness? Certainly, it is our place as medical advisors, not as specialists, to warn our patients, and that means the public at large, as to the time-proven dangers of marriage with a congenitally deaf person as a partner or partners. In addition, if marriages between the tuberculous, luetic and otosclerotic could be forestalled, the whole problem of congenital deafness would be very close to solution. We can, at least, by our efforts, make its incidence practically negligible.

ACQUIRED DEAFNESS

It is, however, in acquired deafness that the direct efforts of the medical profession are challenged.

Most cases of acquired total deafness may be anatomically traced to inflammation of the labyrinth. Usually, the entire labyrinth (static and acoustic) perishes from the inflammation, so in distinction to congenital deafness, we have no hearing remnants and no functions of the static labyrinth. The deafness following middle ear suppuration, not affecting the labyrinth, is generally partial, but tends to become progressively worse as the child grows older.

The most common causes of acquired total or partial deafness in children are meningitis, scarlet fever, measles, influenza and repeated nose and throat infections.

At birth, the internal and middle ears are completely formed and no further growth in size takes place. The meninges are in closer contact with the petrous bone in an infant than they are in an adult, and the internal auditory meatus is wider and not completely filled with nerve as it tends to become later in life. The cochlear opening in a child is also patent. Thus, an infectious disease, such as meningitis, will be more apt to spread into the inner ear of a child than an adult and cause deafness; conversely, meningitis from middle or inner ear disease in a child is one of the most important complications. Measles and scarlet fever are especially prone to attack the child's ear, early in the course of measles and later in the second or third week in scarlet fever.

The process is usually confined in the beginning to the middle ear and generally consists in a suppurative process here, followed by rupture and destruction of the drum membrane, the destructive process being particularly marked in scarlet fever where, at times, the drum membrane seems to almost melt away. The toxemia of scarlet fever and measles may also cause irreparable damage to the auditory nerve and this added to the middle ear destruction may cause total deafness.

Repeated nasal and post-nasal infections are in a child easily transferred to the middle ear by way of the eustachian tube which in children is shorter, broader and more horizontal than in adults.

It can thus be readily understood that during the first five or six years of a child's life, the ears are especially liable to be irrepar-

ably damaged, for the above mentioned etiological factors are peculiar to this period of a child's life.

FUNCTIONAL TESTS

The functional testing of children's ears is rather difficult and in any case it cannot be considered complete until after the child is six years old or more. A quiet room and restful surroundings are essential to the proper testing of ears and it was the almost universal lack of these desiderata that must have lead Cumberbatch, one of the founders of the Otological Society of Great Britain, to write concerning the difficulties of making hearing tests in his hospital: "My hearing tests are handicapped by the re-echoing din of the surgery; babies are screaming in the hollow distance; through the open doors come the crash and rattle of traffic; while in the male 'cross box', a house surgeon is making urgent efforts to pass a silver catheter through a seemingly impermeable stricture, to a running accompaniment of groans and interjections from the patient."

For infants, I have found the auro-palpebral reflex of Bechterew to be the most satisfactory. Here, the eye is shielded by a card or hand and a C4 fork is struck close to the ear. If the fork is heard, a winking reflex will be observed in the upper lid, especially if the eyes can be directed upward. This test is, however, of no use in the diagnosis of the degree of deafness. As further aids in the recognition of deafness in the very young, it is well known that a child should begin to talk when a year or so old, at least a word or two, which may be only intelligible to the parents. If it does not make any effort to do this, the child may be deaf; it may suffer from aphasia, an anatomical defect in the motor area of the brain; it may be an idiot and show other stigmata of that condition, such as convulsions, enuresis, involuntary motions of the head, inability to eat alone and lack of playfulness, or the child may have a hearing dumbness. Here there is no anatomical defect, rather it is a psychological disease wherein there is an overstimulation of other sense organs, combined with some stupidity. The child can hear, but cannot speak, but with proper training gives a relatively good prognosis. All infants are well able to cry but the deaf child does not laugh. When the school age is approached the degree of deafness can be determined either by the usual voice and fork tests or by the use of the audiometer.

A serviceable method in general, is the use of the whispered voice. It is well known that a normal child can hear a whisper at more than 20 feet in a quiet room but this distance is taken as a standard, because educational efficiency and later vocational efficiency are not interfered with in a child or adult who can hear a whispered speech at 20 feet.

A child, with deafness as indicated by any of the above tests, should have the type and degree of deafness further elaborated by an otologist with his more exact methods. This is important for the advice that is given determines the future life of the patient.

It takes ten years of education to fit a totally deaf child for fluent speech and lip reading, and at the end of that time, his choice of a vocation is much restricted. Hardly any cause of inefficiency is more complete than that. It is a great mistake to consign a partially deaf child to a school for the deaf. As Plutarch said: "If you live with a lame man, you learn to limp" and so the hard of hearing child adopts and mimics the mispronounced words of the totally deaf child. The partially deaf child should be taught lip reading by a competent teacher and should receive all the instruction possible in the class room with normal children. But once the child is judged to be so deaf that instructions cannot be given in the public schools, he should be placed in a suitable institution where he can be properly taken care of and taught a useful and gainful occupation.

PREVENTION

The prevention of deafness in children in the last few years has received increasing attention from not only the medical profession, but from other sources, such as the various leagues for the hard of hearing and educational boards. In the end, however, the problem rests with the medical profession. Certainly, no one should treat scarlet fever

or measles without having some way of observing the ears, nose and throat during the course of the illness. An electric otoscope is probably the easiest way of following the ear changes and with the first sign of middle ear disease watchful expectancy should be replaced by masterful activity and the ear drum opened. By the more wide spread use of scarlet fever antitoxin, the toxic phase of the disease can be influenced even though the bacterial cannot.

The early removal of tonsils and adenoids is debatable, but certainly no controversy should exist when the ears are affected by them. Given a child with frequent head colds and upper respiratory infections, sooner or later, the ears will be affected through the eustachian tubes and nothing predisposes to these repeated infections more than do diseased adenoids and tonsils. As to the time of their removal, when it is believed the ears are being affected, they should be removed at once. It is known that pneumatization of the mastoid and middle ear is practically complete at six years of age and it is upon the degree of this pneumatization that the resistance of the middle ear depends. Having had a middle ear infection develop, it is our duty to treat that ear to the best of our ability until the disease has been completely eradicated and has left no complications.

It should be the right of every child to have watchful care of its ears from birth through the school age when infectious fevers prevail and adenoids and tonsils are most likely to require removal. If this is universally adopted, acquired deafness will show a sharp decrease within a few years.

Our attention to the prevention of deafness, both congenital and acquired, is a disinterested service and it brings but little fame, but it shows splendid results and it is a source of constant satisfaction to know that some child who might have been deaf has been spared the affliction.

822 Argyle Building

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Erastus Bradley Wolcott (1804-1880).

By WILLIAM SNOW MILLER, M. D., Sc. D.
Madison

Erastus Bradley Wolcott was born October 18, 1804, at Benton, Yates County, New York, and died at Milwaukee, Wisconsin, January 5, 1880. He was the son of Elisha and Anna (Hull) Wolcott, who came from Litchfield County, Connecticut, and were among the earliest settlers of that section of New York.

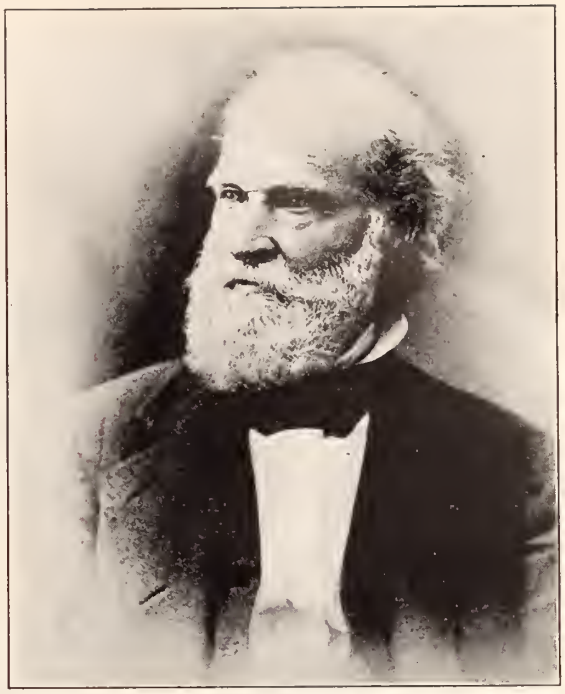
He was descended from a long succession of distinguished ancestors which included Roger Wolcott, governor of Connecticut in 1751 and Oliver Wolcott, signer of the Declaration of Independence, Secretary of the Treasury in 1795, and governor of Connecticut in 1797. His son, also named Oliver, was governor of Connecticut from 1817 to 1927. Of the Wolcotts who have become distinguished mention may be made of Roger Wolcott, governor of Massachusetts from 1893 to 1896 and, in 1900, Ambassador to Italy.

Nothing is known of his early education. He probably had such advantages as the frontier offered in the way of public schools; but, best of all, he had Nature for his teacher and under her instruction he developed a strong, vigorous mind and body. Early in

life he became noted for his physical power and also as an expert shot with the rifle, the shotgun and the bow. It is related that his father came into possession of a bow that once belonged to the Indian chief, Red Jacket, and that very few white men could draw it to its maximum strength, and scarcely one could use it skillfully. In the history of Yates County, New York, it is stated that young Wolcott shot a blunt pointed arrow through the siding of an abandoned meeting house, at the distance of twenty rods.

Having decided to study medicine he began his studies, as was the custom of that time, with a practicing physician, Doctor Joshua Lee, of Ontario. After three years of study he was licensed, in 1825, to practice medicine by the Yates County Medical Society. In order to obtain funds to continue his studies he accepted a position as surgeon with a mining company in North Carolina and later practiced in Charleston, South Carolina, until 1830, when he returned to New York and entered the College of Physicians and Surgeons of the Western District of New York, located at Fairfield, and from this institution he received the degree of Doctor of Medicine in 1833. He made a fine record as a student, especially in anatomy, while at Fairfield, and on graduation he was urged by his professors to settle in New York City. City life, however, did not appeal to him; he preferred the open, free life of the West. Accordingly, in 1835, he took the examination for surgeon in the United States Army and on January 1, 1836, he received his commission. He accompanied the command, under General Scott, which removed the Cherokees west of the Mississippi, and then was ordered to Fort Mackinac. Here he met and married Elizabeth J. Dousman, daughter of a fur-trader at the post. In 1839 he resigned his commission in the army and, resuming private practice, located in Milwaukee where he met with immediate success.

Of five children born as the result of this union but two, a son and a daughter, survived. In 1860 his wife died and in 1869 he married for his second wife Laura J. Ross, M. D., one of the three women first admitted



Erastus Bradley Wolcott
From a photograph in the possession of his grandson, Dr. J. L. Yates, Milwaukee.

to clinical studies at the Phildelphia Hospital, and in 1856 she received her diploma entitling her to practice. By his second marriage there were no children.

Various honors came to Doctor Wolcott and it seems best to enumerate them at this point in the narrative. In 1842 he was appointed by Governor Doty, Surgeon General and he held that office until the day of his death, having been reappointed by Governor Smith the day preceding his decease. In 1846 he was appointed Major-General of the First Division of Wisconsin Militia. In 1850 he was appointed a Regent of the University of Wisconsin and served until 1853. During the Civil War he organized the medical service of the state, selecting and nominating all the surgeons. Whenever any number of Wisconsin regiments became engaged he and his staff of assistants were sent into the field. He took part in organizing the Northwestern Life Insurance Co., and was a member of its board of trustees. In 1860 he was appointed a trustee of the State Insane Hospital. In 1866 he was made a member of the board of managers of the National Home for Disabled Volunteer Sol-

diers. In 1867 Governor Fairchild appointed him a commissioner to the International Exposition at Paris. He was the first vice-president of the Wisconsin branch of the Humane Society. The G. A. R. Post in Milwaukee is named the E. B. Wolcott Post No. 1, G. A. R. He was also interested in developing the water-powers of the state, erecting mills at West Bend and Humboldt. He was a prime mover in building the first railroad in the state.

PROFESSIONAL ABILITY

Turning now to Doctor Wolcott as a medical man, we find that he possessed great professional ability and personal popularity. In the period in which he lived he probably was the best surgeon in the Middle West and one of the great surgeons of this country. Because of his modesty and dislike of notoriety he did not publish the results of his operations, losing in this way much of the reputation he might have acquired. The one operation which will ever keep his name among the great surgeons was the removal, for the first time in the history of surgical practice, of a diseased kidney. This operation was performed June 4, 1861, and was reported, not by himself, but by his assistant, Dr. Charles L. Stoddard, of East Troy, Wisconsin, in the Philadelphia Medical and Surgical Reporter for 1861–62, Vol. VII, page 126. The title is "Case of Encephaloid Disease of the Kidney, Removal, etc." With the exception of a few unnecessary details, I quote in full:

"On the 4th of June last I was invited to assist Dr. E. B. Wolcott, of Milwaukee, in the removal of a tumor from the abdomen of Mr. J., aged 58 years. On examination we found that the patient was a tall, anaemic looking man of a peculiar cast of countenance, indicative of serious organic disease. He stated that he was of healthy parentage, and had good health until the appearance of the tumor six years before that time. The physician in attendance stated that from the first appearance of the disease, some irritation of the urinary organs had existed, but what the deposits were we were unable to learn, as no reliable chemical or microscopical evidence was presented.

"We found the tumor to be large, filling the right hypochondriac region and pressing the abdominal parietes forward about two inches from their natural level. On palpation it was evident that it was semi-solid, having a pedicular attachment, apparently to one of the sulci of the liver, with more extensive attachment to the posterior parietes.

"Having no reliable data to form a diagnosis, other than the present state, after duly considering the patient's anxiety, and his deprivation of general health, we concluded that an operation offered the only chance of ultimate recovery; at the same time we stated to the patient and his friends that the operation was a serious one in his state of health. Our conclusion was, that we had here a cystic tumor of the liver, pressing on the kidney and producing irritation sufficient to account for the albuminous deposit. After the administration of chloroform, Dr. Wolcott proceeded to the removal of the tumor by making an incision diagonally across it down to the peritoneum, which we found to be very much thickened and slightly attached to it. He then proceeded to free it from its extensive posterior attachments, after which he found that the superior attachment was a very dense cord-like structure, about an inch in circumference, and apparently proceeding from the posterior part of the liver.

"Carefully tying the pedicle, he severed this connection with a knife, and after removing foreign matter carefully from the abdomen, brought the edges of the wound together with common sutures and adhesive strips, which was the only dressing used. After the patient was free from the effects of chloroform, morphia and camphor were administered in sufficient quantities to quiet irritation and produce sleep. The tumor weighed two and one half pounds, and on incising it freely, we found undoubted evidence of its being a kidney from a small portion of its upper portion, which had not degenerated, showing the tubules and a portion of the pelvis.

"The patient lived 15 days after the operation, and died apparently from exhaustion,

The Wolcott monument in Lake Park, Milwaukee, Wisconsin
(Courtesy of the Milwaukee Park Board)

caused by the great amount of suppuration which necessarily followed."

It is interesting to note that as early as the 17th century nephrectomy had been done experimentally on dogs. In an article in von Pitha and Billroth's System of Surgery, Heinecke stated that Zambeccarius in the latter part of the 17th century removed a kidney from a dog and the animal recovered. This was done after he had observed at dissections that some healthy dogs have only one kidney.

Simon, of Heidelberg, is generally credited with having performed the first nephrectomy, but his operation, reported in the Deutsche Klinik, Berlin 1870, was not performed until eight years after Wolcott's operation. Simon undoubtedly deserves great honor for having done nephrectomy experimentally on dogs, for undertaking the operation deliberately, knowing what he had to deal with, and for bringing the operation before the medical profession, but the honor of priority is in no wise due to him, for Wolcott's operation was performed in 1861, more than eight years previously.

This nephrectomy was by no means the only major operation he performed. He excised the breast, trephined the skull, performed thoracotomy, did extensive plastic operations for scars resulting from burns, oöphorectomy, Caesarean section, lithotomy, and many other unusual operations. The frontier surgeon did not have the finely equipped hospital of the present day, with its staff of trained assistants and nurses; antisepsis was practically unknown and anaesthetics were just coming into use. His results were remarkable but, "working as he did in pre-antiseptic days he was aided by his own scrupulous cleanliness of hands and instruments."

I have referred to the splendid physique which Doctor Wolcott developed as a youth and his skill with the rifle and bow. Throughout life he was fond of hunting and fishing and often took long trips to enjoy these sports. Age did not seem to diminish his vigor. At one time, he was called to attend a case some twenty-five miles from Milwaukee, the first sixteen miles of which could be covered by rail but the rest of the way he walked. On his return to the station he found that it would be some time before a train arrived so, being in a hurry to reach Milwaukee, he walked every foot of the way home. At another time, when seventy-five years old, he was called to attend a case some miles beyond Waukesha, Wisconsin; on his return the only means of transportation was a freight train and he found that he would be delayed some two hours. Again he was in a hurry and walked, reaching home fresh and hearty.

His practice was extensive, but he did not accumulate money; this was largely due to the fact that he had no system of keeping his accounts and was moderate in his charges. It is related of him that at one time a patient, after some delay, obtained a statement of forty-eight dollars, when, as he said, his bill should have been several hundred dollars and he expected to pay that amount. In spite of his insistence that he take the larger amount, the Doctor was obdurate and would only accept the amount charged.

The case of the fugitive slave, Glover, was one of the picturesque chapters in the history of Milwaukee, and Doctor Wolcott played no small part in liberating him from the county jail and setting him on the way to liberty.

Doctor Wolcott died January 5, 1880, of pneumonia contracted in a chilly court room at Horicon, Wisconsin, where he had gone to testify in behalf of a brother practitioner who was unjustly charged with malpractice. The universal sorrow which his death occasioned was expressed by the great number who attended his funeral, not only from Milwaukee and the Soldiers' Home but also from the surrounding towns, his skill as a surgeon and his kindly disposition, winning for him the love of the poor and needy as well as that of the more fortunate.

Laura Ross Wolcott, Dr. Wolcott's second wife, died December 8, 1915. Previous to her death she made provision for the erection of a monument to the memory of her husband. This was erected in Lake Park, Milwaukee, and was unveiled June 12, 1920.

In his dedicatory address Col. J. A. Watrous said, "It is most fitting that in one of Milwaukee's finest public parks there should be erected and dedicated a statue to the memory of one of the first and best citizens, an American of Americans."

Tinker, M. B. The first Nephrectomy. Johns Hopkins Hosp. Bull., 1901, vol. xii.

Yates, Marion Wolcott, Erastus Bradley Wolcott, Amer. Medical Biographies, Baltimore, 1920.

Milwaukee Journal, June 13, 1920.

Professional Independence

By H. P. GREELEY, M. D.
Madison

The medical profession is losing much of the noble independence of former times. Slowly and insidiously as we have grown in numbers and power we have let go or bartered away our birthright for a mess of pottage.

From the annual meeting of the American Medical Association to the monthly meeting of the county medical society commercial interests wield a power and an influence out of keeping with their true value. The rental of space for exhibits makes medical meetings financially possible under existing conditions. And the space so taken is censored by the Society, but very often the character of the exhibit is of questionable value and much premature, unscientific material is exposed to the gaze of the innocent and credulous general practitioner. Though I recognize the value of these exhibits and appreciate how carefully they are censored, still the principle is unsound and the profession should be independent of this source of income.

Not only do the interests pay well for exhibit space at national, sectional and state meetings, but they are invading other important fields of medical activity. How many monthly journals and bulletins are distributed to the thousands of physicians of America without cost? Many of them of an attractive appearance and quasi-scientific order, containing original articles, attractive pictures and biographical sketches of famous physicians, case reports, summaries and abstracts of medical literature, all carefully assembled for the one purpose of introducing or emphasizing the value of some particular products of some particular manufacturer.

In the next instance the doctors' offices are overrun with samples which the manufacturers hope will be distributed to patients who in turn will advertise some particular article to loving friends and in that way a trade will be developed directly between the druggist and the consumer, generally to the detriment of the consumer and certainly to the disadvantage of the physician. At other times these articles are distributed to the physician in the hope that he will, in the future, always use Rose's salicylates, or Hill's digitalis, or Blank's mineral oil.

In the next instance the commercial interests are stepping into a kind of work which takes a load off the over burdened mind of the county secretary and of the staff secretaries of hospitals, those slaves of the American College of Surgeons. We all know the job of getting up programs for these meetings. Along comes the Eureka Manufacturing Co. with a moving picture film and operator who takes the whole load off the mind of the secretary. He can now promise entertainment at no trouble or expense. An uninterested staff can fulfill the requirements of membership among Class A hospitals and smoke while the drummer boy talks and turns the crank. Refreshments are served and another staff meeting is over.

What more undignified and debasing spectacle than that the Goose Neck Catgut Co. should be presenting the program before the University Medical Society or that the Smilax Refining Co. should take over the staff meeting on such a date for demonstrating the need of universal intestinal lubrication?

Very soon we will be getting all this and more by radio, sandwiched in between our favorite jazz selections. The Cascarade Orchestra will supply medical information and music "while you sleep."

Of course, the commercial interests are not waging any war to get control of the medical profession in America. Their problem is solely commercial and their interest is in devising ways and means of overcoming the rivalry of competing firms.

It is the medical profession that is succumbing to their insidious program and becoming commercialized by allowing the interests to usurp professional activities. Will the profession remain a profession or will it also become a trade? Does the profession care enough about its independence to finance its scientific gatherings? Does the majority attend the exhibits rather than the scientific sessions?

WHAT SHOULD BE DONE?

Is there anything that we can do or should do about it? Yes, there are many things which we can do. Let us ask our medical organizations to help. Let the American Medical Association and the state societies become more interested in these matters. Let our Class A medical schools show to the profession at large their activities and the advances in scientific medicine. Let the Council on Pharmacy and Chemistry and the Council on Physical Therapy annually give us the advances and exhibit the true from the false in therapy. Let the State Board of Health exhibit advances in the public health field and let the State Laboratories exhibit each year all the phases of the state service to physicians with demonstrations of standard procedures which physicians themselves should have available in their own offices as well as those services available through the State Laboratories.

This much the state may do and much more could be done by the American Medical Association. That is the logical clearing house for much that is going on over the country. The American Medical Associa-

tion could cooperate in furnishing technical exhibits, pharmacal advances, methods of applying therapy, instruments and drugs, laboratory apparatus, medical literature and journals. All these things should be demonstrated to the profession by the profession. The American Medical Association should, as a clearing house, help in the demonstration of real advances of proven worth thus eliminating much of the type of thing we get now, where the best exhibit may be the least valuable one, and where many things are made much of, which in another year will be buried deeper than oblivion. Medical meeting places which have to be paid for by commercial interests should gradually be supplanted by meetings sponsored and solely supported by the profession for the profession. To no better use could invested funds and endowments be put than this; a policy by which the profession would be made independent of commercial advertising. I see no good which can come from the infiltration of medical activities of all kinds by the drug and specialty houses. I see every reason why the profession should maintain the highest standards of professional ethics and absolute independence. It is not conceivable that professional meetings could be given up if revenue from these outside sources should be withdrawn. It is highly desirable that the profession conduct its own scientific assemblies.

Where is the money to come from? From the profession in the shape of increased dues, in the form of bequests and endowments and from help given the states by loan of material, brains and money from the American Medical Association. If it took fifty years to accumulate a fund it would be an incalculable gain to the ideals and the morale of the profession.

Osler saw the future clearly and many times warned the profession of the dangers to it of commercial advertising. Where is the Osler who will rise to help purge the profession of this evil?

SECTION ON RADIOLOGY

H. B. PODLASKY, M. D., Editor

Urological Roentgenology; An Aid in General Practice*

By WILLIAM E. BANNEN, M. D.
La Crosse

The subject, urological roentgenology, as an aid to the man in general practice, is timely, and I believe worthy of careful consideration. Roentgenology has been a great aid to the urologist in the investigation and diagnosis of urological pathology, in fact the systoscope and the radiograph have been the urologist's most efficient diagnostic implements. As we look back over the development in the diagnosis and treatment of urological diseases, and consider the advancement made in urologic diagnosis, we are compelled to give a great deal of credit to the roentgenologist. It is true that twenty-five years ago a cystoscopic examination of a patient was approached with as much careful preparation as today surrounds the ordinary laparotomy, and the physician who was skilled in the use of the cystoscope was considered to have as rare an accomplishment as has the bronchoscopist of today.

The urologist of today, as a specialist, and as a diagnostician rating far above the common conception of the physician treating veneral diseases, has had a special careful training in the pathologic conditions of the entire genital urinary tract. However, he does not have a monopoly of the treatment and diagnosis of urologic diseases, since a large percentage of these cases first present themselves to the man in general practice, and we believe that it is one of the outstanding needs of present day diagnosis and treat-

* Presented before Green Bay Academy of Medicine and State Roentgenological Society, May, 1930.

ment—that the urologist bring to these men in general practice a concise and practical knowledge of the present day urology. Not only the signs, symptoms, and diagnostic points that will enable them to avoid the pitfalls of diagnosis, and the mistakes in treatment that have been, and are still far too prevalent. Only three years ago I collected twenty cases of ureteral obstruction, and of these twenty cases, sixteen had been subjected to from one to three surgical attacks on the abdomen without relief from their symptoms and pain, and in each one of these cases, the careful eliciting of the history, and an alertness of urologic signs, would have made possible a urologic diagnosis before the surgical treatment had been tried. It is true that many of these do not conform to some of our text book pictures, but to the diagnostician the history of dysuria, micturia, hematuria, or a tenderness over the ureter, kidney, or a pelvic examination with tenderness in the bladder or vesicle portion of the ureter or seminal vesicle, should give sufficient cause for a careful urologic investigation. Only last week Professor Harris, of the University of Wisconsin, referred to a case having had seven operations, and being advised to have the eighth with a Trichomonas vaginalis infection, the diagnosis made from the history and the negative findings, only after a careful microscopic examination revealed the Trichomonas.

I will speak chiefly of the diagnostic value of various radiograms, pyelograms, uretergrams, cystograms, and vesiculograms, and I do not propose to discuss indications, or counter-indications for their employment as aids to diagnosis. There may be some discussion as to the advisability at times of resorting to urography in cases of renal tuberculosis—some discussion as to the advisability of taking bilateral pyelograms, but I will not enter the discussion of this at this time.

THE FLAT RADIOGRAM

We do believe, however, that the ordinary flat radiogram, or so-called K. U. plate, as taken so frequently, is a waste of the physician's time and the patient's money and is not justified, even though it may reveal a calculus or calculi, either renal, ureteral, or vesicular, and that the surgeon who will operate on a stone in the kidney or ureter without a careful urographic examination is as culpable as a surgeon who will remove a carcinoma of the breast without good stereoscopic radiograms of the thorax for metastasis in the bones or lungs. So it is with the K. U. plate, the information obtained is not sufficient and some of the special urography is necessary for an accurate diagnosis. We frequently have patients who will protest that they have had one to three x-ray pictures of the kidneys and ureters, and have been told that there is no pathology present. This may mean that the plate did not show any calculi, ten per cent of which are silent stones and do not throw a shadow, whereas a good pyelogram or pyelo-uretergram will demonstrate not only the location of a stone, but also determine the method of treatment. The flat plate will give no clew to the amount of renal damage, and will not tell whether there may be a normal kidney on the opposite side. An accurate diagnosis is of great value in the prognosis and is necessary in the determination of the proper treatment of the case. Oftentimes a better knowledge of the function of the kidney may be obtained from a good pyelo-uretergram than from the various functional tests employed, and that where urography is properly done with the opaque solutions there are no more complications or reactions than are encountered in cases where simple cystoscopy and ureteral catheterization are performed. An analysis of a considerable number of cases has shown no more reactions following urography, than in those in which urography was omitted. It is true, that in a number of these cases negative findings are of as great value as those in which positive urologic pathology is found, and these negative findings are of sufficient importance to warrant the urographic examination. I shall make no effort to enumerate all of the urographic pathological conditions in which urography provides an aid to diagnosis, but shall mention a few of them that I believe are outstanding, and show on the screen slides to demonstrate these pathological findings, many of which could not be diagnosed without the aid of the radiogram.

TYPES OF UROGRAPHY

The various types of urography might be mentioned in passing, as air urography, that is, distention of the renal organs with air. This has not been of a great deal of value as an aid to diagnosis as in it we get only the size and contour of the renal pelvis, the ureter and the bladder, but we do not get the emptying time of the renal pelvis, nor the clear cut picture as with the opaque solutions. In cases of ureteral or renal stone air urography has a very distinct diagnostic value. Retrograd urography through the cystoscope has been by far the most satisfactory method employed so far, and gives in addition to the size and contour of the renal pelvis, ureter and bladder, the emptying time of the renal pelvis and the excursion of mobile kidneys without change in the patient's position. In certain cases of retrograd, urography can be obtained with the patient in Trendelenburg position by simply filling the bladder with an opaque solution. At the present time much interest is being evinced in the intravenous method of obtaining urographic radiograms. This method has been recently brought out by Professor Von Lichtenberg of Germany, and will, undoubtedly, be used to a great extent in urology, especially by men not trained in the use of the cystoscope as its introduction is as simple as cholecystography. However, so far as we have been able to determine its value will depend largely upon the ability of the interpreter of the radiogram, also the ability to take excellent radiograms. In intravenous urography it is difficult to get a good uretergram and the emptying time of the renal pelvis cannot be determined, but it does give promise of being one of the best renal function tests that we will have as the rapidity of the excretion depends almost entirely upon the renal function. Cystography is of great importance in determining pathology of the bladder, especially diverticulae and neoplasms, as well as contracted bladder. Seminal vesiculograms are of considerable interest to the urologist, not only for diagnostic value, but numerous cases have cleared up rather rapidly after the vesiculogram has been taken, and it seems to have some therapeutic value. Probably the most important urographic pathology, the one most commonly overlooked, and the one most confusing because of its varied symptomology, and the one on which most abdominal pelvic mistakes have been made, is that of hydro-ureteral nephrosis. I do not propose to enter the controversy regarding ureteral stricture, but I am sure that no one will deny that there are numerous ureteral lesions of an obstructive nature, either within the ureter or extra-uretral, and that these can only be diagnosed by urographic study. I will demonstrate some of these with slides—ureteral kinks, abberant vessels, ptosis of the kidney, ureteral tumors, carcinoma, fibroma, and papilloma.

CONGENITAL DEFORMITIES

Congenital deformities, such as horse shoe kidney, solitary kidney, ectopic kidney, ptosed kidney and the double kidney can only be diagnosed by urography. The neoplasms of the kidney and such deformities as cysts, solitary cysts of the kidney, polycystic kidney and nephromae can only be diagnosed early by urography, and it is to these early diagnoses that we are pinning our hopes for a better prognosis and appeal to the general practitioner and those who first come in contact with vague urologic symptoms in patients, to have a careful urologic investigation to obtain these early diagnosis on these patients, who are now seen with long standing diseases which result in destroyed kidneys and damaged bladders. It may be stated that these tumors are oftentimes symptomless, and are only discovered when their size and position cause symptoms. This is not as true as it may seem, as they will almost without exception, have caused sufficient symptoms to have had a diagnosis made early, but they come in as advanced cases and generally too late. Dr. Pennington of Chicago called attention to the fact that "bleeding, pain, and diarrhea", the text book symptoms of carcinoma, are not the premonitory symptoms, and that by the time they put in appearance the case is often inoperable. The same rule applies to renal pathology. Prostatic obstruction, with its resultant damage to the kidneys and the pa-

tient coming in with a marked renal damage, should have been recognized early and the patient relieved before this damage has occurred and the patient comes in an exceedingly poor risk. To the general practitioner, if I could make a plea so strong, and in this paper carry this message so that it will make a lasting impression, namely, that hematuria is always of potential seriousness, and that no case of hematuria should be treated until it has been carefully investigated, and a cause determined, a large number of our inoperable tumors would be diagnosed early and could be cured; a large number of tuberculous patients would get the advantage of general tuberculous and sanitarium treatment, and if our urethral obstructions, prostatic and otherwise, would be diagnosed early and treated early our mortality and morbidity would be greatly lessened. I am willing to admit that some cases of hematuria may be of comparatively little importance, may be due to alcoholism, a hemorrhagic nephritis, but the symptom of hematuria is of sufficient importance to warrant careful investigation and not treatment with antiseptics and so-called urinary sedatives and it is a serious indictment of the first men who see patients with hematuria, that not one in four whom we see with urologic tumors have been advised to have a urologic investigation until the hematuria has recurred from two to as high as six times.

Pyelitis of pregnancy is another condition that has been so frequently overlooked although obstetricians and urologists have been emphasizing it for the past four years, and I wish at this time to call the attention of all men in general practice, who are treating obstetrical cases, to be on the alert and recognize their cases of pyelitis of pregnancy before they go on to a serious damage of the kidney. These cases are overlooked because the routine clinical examination does not show albumen and microscopy is neglected and the pus cells are not recognized in the urine, or if pus cells are recognized in a voided specimen they are considered of little or no consequence. There is a false impression as to the danger of obtaining catheter specimens and producing a cystitis or urethritis and if we can overcome this prejudice and obtain our specimens for examination by catheter these cases of pyelitis of pregnancy will be recognized early. At this time I wish to state that there is very little danger of producing a cystitis by catheterization with proper technique, unless the bladder is over distended or has been traumatized from operative procedure or the trauma of labor. No discussion of this subject of urography would be complete without the mention of tuberculosis. We believe that the pyelograms and uretergrams in our cases of renal tuberculosis reveal sufficient positive valuable evidence to more than offset any possibility of damage, and we do not hesitate to make pyelograms and uretergrams in our cases of renal tuberculosis, and in the past three months have been able to demonstrate three definitely arrested or cured cases of renal tuberculosis. One of these cases of laryngeal tuberculosis developed a streptococcus infection, facial and the autopsy revealed quiescent or arrested bilateral renal tuberculosis and tuberculous ureteritis, confirming the urographic findings. Renal urography in trauma to the kidneys is often of great value and I have in my records several cases where the determination of conservative or operative treatment depends entirely upon the urographic findings. There is one other radiographic finding of great value in urologic cases that I believe is worthy of mention to the man in general practice, as I believe it is frequently overlooked, and that is a careful stereoscopic x-ray of the lumbar and sacral portion of the skeleton for anomalous fusions and congenital deformities such as spina bifida occulta, as there are very frequently the underlying causes of various cord lesions resulting in urinary symptoms such as incontinence and retention of urine, and when the child with incontinence is presented and after as usual the various methods of treatment have failed, consult the radiologist and look carefully for skeletal deformities to explain the condition, and failing in this, consult the urologist for a urographic study for congenital deformities either renal, ureteral, vesicle or urethral.

THE JOURNAL CLINIC

Intestinal Obstruction Due to Gallstones; Case Report

By V. F. MARSHALL, M. D.; P. L. HEITMEYER, M. D.;
M. E. SWANTON, A. B. (Interne)
Appleton

A female, age 54, an invalid who had been confined to bed for ten years because of arthritis deformans, was sent to the hospital with the following complaints:

1. Severe pain and tenderness in the right upper quadrant for 1 week.
2. Nausea, vomiting and weakness 1 week.

Onset and Course: The pain came on suddenly a week previously, severe, knife-like in character and radiated to the back between the shoulder blades. Morphine was necessary to give relief. She had been vomiting frequently and when seen she had vomited several fasceted stones.

Past History: During the past five years she has had many similar attacks of sudden acute pain in the right upper quadrant extending through the right shoulder but never as severe as at the present time and not accompanied with vomiting. She has had generalized arthritis 15 years and for this condition had consulted very able internists. As a child she had measles, chicken pox, parotitis, and pertussis. Menopause came at 48 years of age and has been complete since. She was married at 17 years and has had two children both of whom are in good health.

There was one miscarriage after her first pregnancy.

There have been no operations and no accidents.

Physical Examination: This patient was a short, stout, gray haired female with a pinched expression and with all appearance of being critically ill.

The positive physical findings were as follows:

The sclera had a yellowish tinge, the skin was clammy and the tongue dry and coated. The temperature was 101 degrees, pulse 110, weak and irregular. The respiration 30 and the blood pressure 100 systolic and 70 diastolic.

The abdomen was moderately distended and there was marked tenderness and rigidity in the right hypochondrium.

The liver gallbladder, kidneys and spleen were not palpable.

Laboratory Reports:

Blood

Hb. 95%
Eryth. 4,510,000
Leuc. 13,200
Poly. 85%
S. L. 12%
L. L. 3%

N. P. N. 166 mg. per 100 cc. blood.
Bl. Urea N. 62.4 mg. 100 cc. blood.
Bl. Sugar 146 mg. 100 cc. blood.
Bl. Creatinine 4.1 mg. 100 cc. blood.
Blood Wassermann was negative.
Icterus Index 26.6

There was one plus albumin, a few hyaline and granular casts, one plus leucocytes, one plus epithelial cells and three plus bacteria in the urine.

A diagnosis was made of cholelithiasis, a gastrointestinal biliary fistula and arthritis deformans.

But because of the patient's critical condition supportive treatment was given in the hospital for three days before operation was done. The patient was operated under gas-ether anaesthesia, spinal anaesthesia having been attempted but owing to arthritic changes in spine attempt failed. Exploration of the abdomen revealed dense adhesions between the pyloric end of the stomach, duodenum, gallbladder and liver, forming a mass which appeared to be a carcinomatous. There was a dense adhesion causing a marked angulation of the ileum, mesenteric glands were markedly palpable. As the condition was evidently inoperable and the patient's condition critical the abdomen was at once closed. The patient seemed to be in fair condition the following day but thereafter the abdomen became more distended, the temperature increased and the pulse grew weaker and more rapid. Fecal vomiting continued. Death occurred four days after operation.

Autopsy Report: Although a complete autopsy was done, space will be taken only for the abdominal findings and for the anatomic diagnosis.

Liver: The liver was enlarged and of a friable, doughy consistency. Surfaces made by sectioning were of a cloudy, fatty, yellow appearance. The peritoneal covering in the region of the gallbladder was greatly roughened and thickened.

Gallbladder: Numerous dense adhesions surrounded the gallbladder binding it to the surrounding structures, especially to the duodenum. There was a large perforation from the gallbladder extending through the duodenum, opening into it at a point just above the entrance of the common duct.

Adhesions around this area were very heavy. The gallbladder was empty. Its mucosa was thickened and rough.

Pancreas: The pancreas especially at the head, was enlarged and nodular and was bound to the duodenum and gallbladder by a mass of dense adhesions.

Spleen: The spleen was about double the normal size but was normal in color and consistency.

Stomach: The contents of the stomach were fecal.

Intestines: The small intestines were distended with fluid and gas to a point at the midportion of the ileum where there was present a gallstone the size of a small hen egg. Below the stone the ileum was collapsed.

Uterus and Adnexa: The uterus and adnexa were somewhat atrophic.

Kidneys: The kidneys were grossly normal.

Anatomic Diagnosis: Intestinal obstruction (due to gallstone at midportion of the ileum); fistulous opening between the gallbladder and the first portion of the duodenum; cholecystitis, chronic (with massive adhesions to adjacent organs); hepatitis, chronic; pancreatitis, chronic; endocarditis, chronic (rheumatic type); arteriosclerosis (especially involving aorta); hypostatic pneumonia (dependent portion of both lower lobes); generalized, deforming arthritic joint changes.

COMMENT

This report serves to emphasize the value of postmortem examinations. Hereby such examination disclosed fairly completely the pathological changes that had occurred in this rather long change of events and opened before us the last chapter, so to speak—that of the obstructing gallstone.

Fatty Embolism Following Fractures

By ROBERT Y. WHEELIHAN, M. D.
Milwaukee

Fatty embolism is one of the most frequent and least often recognized complications following the fracture of bones. The victim of this calamity most often sinks gradually or suddenly into an alarming condition with cyanosis, dyspnoea, and cough, or he may lapse into a state of mental cloudiness, stupor, coma or convulsions, and die. The diagnosis is difficult during life, and, until recent years, the condition has been called shock, delirium tremens, toxemic coma, or no diagnosis has been made.

There were few cases of fatty embolism reported in America prior to 1913 when Warthin called attention to this condition, and reported twelve cases which had not been recognized during life, and were discovered during the routine study of 560 autopsies. Nine of these instances followed fractured bones. Many cases have since been reported.

During the period from January, 1929, to August, 1930, there were observed in the surgical department of the Milwaukee Hospital, two fatal cases of fatty embolism, and there were two instances with recovery in which it was felt that this diagnosis was justified.

CASE REPORTS

Case 1 (Doctor O. R. Lillie)

A man, aged 59, a railroad crane operator, fell a distance of twenty feet, sustaining simple fractures of the right tibia and fibula. He was unconscious for a few minutes after the fall, but was fully conscious when brought to the Milwaukee Hospital by ambulance. The leg was immobilized without manipulation. His blood pressure was systolic 134, diastolic 84, and his pulse rate was 86. Six hours after the accident he was drowsy and could not be aroused. His systolic blood pressure was 160, diastolic 100; his pulse was 60 and irregular. There were present projectile vomiting, spasticity of both upper extremities and profound stupor. Spinal puncture yielded negative results. A bilateral, subtemporal decompression was done, under ether anesthesia, for subdural hemorrhage, with negative results. His temperature rose, the pulse became more irregular, and death occurred 48 hours after the accident. Post mortem examination, limited to the brain, revealed the following: "In cutting through the brain, there are noticed multiple red spots the size of a pin head which cannot be wiped off. Microscopic examination shows distinct hemorrahges surrounding the vessels. Almost all of the vessels are filled with a substance which stains intensely with Sudan III. Diagnosis: Multiple fatty embolism of brain". This intensely interesting case directed our attention to fatty embolism.

Case 2 (Doctor J. O. Dieterle)

A man, aged 66, a manufacturer, fell down icy steps and lay exposed one-half hour before being found. He was brought to the hospital the second day, by ambulance. Physical examination revealed mitral heart disease, and contusion and swelling of the left leg and thigh. His systolic blood pressure was 122, diastolic pressure 78. The urine examination was negative. X-ray revealed a fracture through the neck of the left femur at the intertrochanteric line with the shaft rotated slightly outward. The leg was immobilized with sand bags and a cast was to be applied the following morning. Early the third morning the patient could not be aroused. He was cyanotic and his respirations were of the Cheyne-Stokes variety. His pulse was 114

and irregular. The systolic pressure was 150, the diastolic 56. A diagnosis of cerebral fatty embolism was made. He was digitalized. The following day, the man was semi-conscious and responded faintly when spoken to. His pulse and respirations were still irregular. The non-protein nitrogen was 58.7 mg. His temperature was 103, pulse 120 and respirations 30. His general condition grew rapidly worse with increase in pulse rate, more irregular respirations and rising temperature. He died on the 7th day after injury. Post mortem examination showed multiple fatty embolism of the brain, lungs and heart muscle, chronic cholecystitis, cholelithiasis and nephrolithiasis.

Case 3 (Doctor T. S. O'Malley)

A man, aged 34, a press operator, was struck by a large sheet of steel and sustained compound, comminuted fractures of the right tibia and fibula, with considerable displacement. The leg was immobilized in a basket splint, and hot dressings applied. The second morning the patient complained of cough. Physical examination at this time was negative. The same afternoon the patient became very restless, and talked irrationally. His temperature was 103, pulse 120 and respirations 30. The diagnosis of multiple fatty embolism of lungs and brain was made. The third morning the man was very listless, responded only faintly when spoken to, and his speech was thick and almost unintelligible. Heart and lungs were negative. There were involuntary movements of urine and feces. The urine showed fat droplets in moderate quantity. The non-protein nitrogen was 35 mgs., and the blood sugar was 77 mgs., per 100 cc. The white blood count was 14,100. The fourth day he was clearer mentally, and progress became gradually better, until on the sixth day following the accident he was entirely normal. He made a perfect recovery from the fatty embolism, and reduction of the leg was accomplished ten days later.

Case 4 (Doctors O. R. Lillie–R. Y. Wheelihan)

A man, aged 46, a railway switchman, was caught between a truck and a box car and sustained multiple compound fractures of the left tibia and fibula with no displacement, and necessitating no manipulation. He was brought to the Milwaukee Hospital by ambulance, and the leg was immobilized and hot dressings applied. The following day he became very restless, irrational, made facial grimaces, and waved his arms as he dozed. He could be aroused, but was unable to orient himself. His temperature was 101, his pulse 110 and respirations 24. No fat droplets were found in the urine. The diagnosis of fatty embolism or delirium tremens was made, but his relatives and associates stated positively that he had never been known to take a drink. He cleared up slowly, and was entirely normal on the 4th day.

Fatty embolism is most commonly encountered following fractures of the long bones. In a series of 100 post mortem examinations of patients who died following severe bony injuries, Buerger found only one case which did *not* show evidence of this condition. It should also be remembered that fatty embolism may follow any surgical operation in which fatty tissue is traumatized—notably mammectomy and ventral herniotomy.

PATHOGENESIS

In the pathogenesis of fatty embolism, according to Warthin, there must be free fat at the site of injury, broken blood vessel continuity, and some mechanism whereby fat enters the circulation. It is common experience to find liquid fat in operative wounds. At the site of fracture there is liquid fat mixed with blood. In bone the blood vessels are surrounded by calcified osseous tubules. The walls of the vessels are held fast to the walls of the tubules by fine strands of connective tissue, and these vessels therefore cannot collapse. Warthin maintains that there is increased tension at the site of injury due to progressively increasing hemmorhage which causes fatty globules to enter the circulation.

A newer conception of the pathogenesis has been developed by Lehman, Moore and McNattin. They believe that there is not enough fat present even in the *largest* bone in the human body—the femur—to cause fatal fatty embolism, and base their belief upon results of experiments in which varying amounts of fat were injected into the veins of dogs. The fat therefore must have its origin elsewhere in the body. Their conception is that ultra-microscopic particles of fat, normally present in blood plasma, are caused to coalesce into coarser globules by chemical or physical agents present in the body as the result of disease or of injury. This has been caused in the living dog by ether, and in the test tube by the degenerative products of any crushing injury; crushed muscle, hemoglobin, or histamin. Thus the bone alone is not responsible for the development of fatty embolism. The question of what actually takes place to cause fatty embolism is therefore not known, but

further experimental work may shed some light on the subject.

Once in the venous circulation, the fat globules are carried to the lung capillaries and filtered out. When large amounts of fat are present, some fat passes through the lungs and is carried to all other organs of the body. The severity of the symptoms depends upon the amount of fat in the circulation and the locations of lodgment. Thus a small amount of fat in the brain may be fatal, while a relatively large amount in the lungs may not cause much damage. All tissues will stand a certain amount of fat before symptoms arise. Fat is excreted through the lungs and kidneys.

SYMPTOM COMPLEXES

Two main symptom complexes have been described; the cardio-respiratory, and the cerebral. In the cardio-respiratory form, the fat becomes lodged in the pulmonary capillaries and coronary vessels. Fatty emboli in the coronary arteries cause infarction of the heart muscle and give rise to rapid and irregular heart beat, with a great drop in blood pressure and rise in venous pressure. When the lungs are flooded with fatty droplets, there may develop suddenly, or gradually, dyspnoea, cough, cyanosis, frothy and bloody sputum containing fat droplets, and signs of pulmonary edema. The temperature is usually elevated, but may be subnormal. There may be a prodromal period of restlessness, headache—even stupor—or the patient may suddenly develop and suffer from air hunger, with coincident intense epigastric or precordial pain. The respirations may become irregular and of Cheyne-Stokes character, and death may follow due to respiratory or cardiac failure.

The cerebral form occurs usually within three to eight days after injury, but may occur within a few hours. As the fat lodges in the minute brain capillaries, there is congestion, stasis and consequent headache, followed by drowsiness, mental cloudiness and stupor. Vomiting, delirium, hallucinations and coma may supervene. The skin is pale and may contain petechiae; the lips are blue, and there may be convulsions or paralysis. In the cerebral form the symptoms of unlocalized brain injury are present. The symptoms of the respiratory form are usually added to the cerebral form; the temperature usually rises over 104 degrees, and the outcome is most often fatal, but recovery sometimes does occur.

Fatty embolism should be looked for following any bony injury. The development of restlessness, sleepiness, coma, cough, dyspnoea and signs of pulmonary edema, make the diagnosis of multiple fatty embolism very probable. The finding of free fat in the urine is positive evidence. At times, the diagnosis may be very difficult, especially if head injuries exist. Many deaths, supposedly due to shock may be, in reality, due to fatty embolism. In shock, there is no free interval which elapses before symptoms begin. Intra-cranial hemorrhage cases may show choked disc, and the symptoms may or may not be those of a localized brain injury. Le Count and Gauss studied fourteen cases of fatty embolism. In only one case had the condition been recognized before death, and the diagnosis of delirium tremens had been made eight times. The correct diagnosis is, at times, of tremendous medico-legal importance, for fatty embolism is an intra-arterial phenomenon which always occurs ante-mortem. Any case of death following the slightest bodily injury should be examined post mortem for the presence of fatty embolism.

The prognosis is always grave. In those cases which develop suddenly after injury, death may be a matter of hours, and often the diagnosis can be made only at post mortem. When the onset is less rapid, the outlook is equally serious, and the majority die, but there are some cases which recover.

When fatty embolism develops, the treatment is purely symptomatic and supportive, with absolute rest as the essential consideration. If recovery occurs, no manipulation should be undertaken for a period of at least ten days. In any case of fracture, absolute rest and immediate proper immobilization of the fragments with avoidance of massage or tight bandages, will reduce the incidence of fatty embolism.

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EDITORIALS

OUR MISTAKES

NO MAN of progressive thought and action will avoid making mistakes. Some few will be serious; many will fall in the "might have been serious" classification.

The altogether natural tendency is to minimize our errors and report our success. That is such a basic human failing that we cannot refrain from calling particular attention to the author in this issue who has taken inventory of his errors of commission and omission so that those particular errors might not again creep into his practice. He has given us all something tremendously worth while. He has the courage of his convictions and in the hope that it may be of profit to others, writes that which most of us never mention to others.

We commend Dr. Foshion's article to our every reader.

PROFESSIONAL INDEPENDENCE

WE PUBLISH elsewhere in this issue, a thought-provoking article from the pen (or typewriter?) of Dr. Hugh Greeley. It will, we imagine, create a discord in some quarters and, in others, set responsive chords of approval to vibrating in sweet, harmonious strains.

The writer of this editorial agrees with much that Dr. Greeley says, but not with all of it by any means. That we are in danger of being swept too far into the channels of commercialism, there can be no question whatsoever. But, speaking figuratively, that we must keep away from the water because it occasionally goes beyond its bounds and ruthlessly destroys life and property, is unthinkable to venturesome spirits.

Medicine, together with all the other arts and sciences, owes an incalculable debt to commercialism and industrialism. But prostitution has never been a beautiful means of meeting obligations. And that, of course, is what Dr. Greeley's vigorous words of protest are directed against. In that we follow him faithfully. But let us not forget that the builder of a cheap car which takes millions into God's great open spaces and thence to health is no less a physician than some who occupy high positions in medical societies.

Coming closer to our realm, is the honest maker of vaccines, serums, etc., less deserving of respect for having well organized producing and research laboratories than is the individual bacteriologist whose operations are limited to test-tubes and possibly a home made incubator? Were hand-rolled pills, and powders (measured largely by guess and by eye) in any wise superior to the more "elegant" modern pharmaceuticals? Many of our instruments, our x-ray machines and much of our hospital equipment would be crude, cumbersome, and far more costly except for the engineering and mechanical skill that commercialism and industrialism have brought to our assistance and service.

Dr. Greeley is quite right in protesting that the scientific work of commercially dis-

interested organizations and individuals must not be crowded out of our circles by better organized and more aggressive business corporations. But this can be accomplished without snobbishness or insularity. After all, aggressive commercialism and industrialism tend to brush away the cobwebs. It is too bad if occasionally a treasured bit of bric-a-brac is swept away too. But life is like that. H. E. D.

"QUACK DRUGGISTS"

UNDER this title in 1903 we said that such should be marked and shunned by the medical profession. Today we see a variation of tactics of the quack druggist who now lends his name to sponsor locally national advertising of a deceptive, highly questionable or fraudulent nature. In view of this local "tie-up" between the home quack druggist and the national patent medicine vendor in the advertising page, we think it timely to repeat our editorial of twenty-seven years ago.

"The medical profession has long been familiar with the method of the medical quack, and the respectable element of the profession is unanimous in condemning this fraudulent class. Little is said, however, about another species of quack who bears a more or less close relation to the medical profession, namely, the Quack Druggists. A glance at any of the metropolitan daily papers will reveal their identity. They are numerous, bold, active, and even more unscruplous than the medical quack. They are the men who advertise that "the operative treatment of hemorrhoids is a failure, is dangerous," etc. "Skinem's Healing Pile Salve for sale only by Skinem & Co., Druggists." "Don't waste time and money on useless treatment—go to the—Drug Store and get a free sample of Dr. Blank's positive cure for all forms of Catarrhal Disease—never known to fail. Interesting demonstration in the front window by young woman disguised as a nurse." "Are your vital organs becoming weak? No need to consult a physician. Robinson & Co., Druggists, put up a preparation known as Parisian Sexual Nerve Promoter, copied from a prescription by a celebrated French physician and prescribed widely by the medical profession. $1.00 per box—cheaper than a consultation by 50%." "Dr. Bunion's Maw Maw is sold under our personal guarantee as to its efficacy," etc. etc., ad nauseam.

"These are the men who should be marked and shunned by the medical profession. They bear the same relation to the pharmaceutical profession that the advertising medical mountebank bears to the profession at the outskirts of which he hovers and plies his vulturous business.

"This class of druggists is not entitled to support as honest members of the pharmaceutical craft. They are pharmaceutical pirates and should be regarded as such not only by medical men, but by honest professional druggists as well."

CIRCUMSTANCES ALTER CASES

WHEN tuberculosis led all other causes of death, as it did only a few years back, practically all persons of 18 and over were *infected.* Tuberculin testing, as a diagnostic sign, therefore, had little practical value. Negative reactions were very significant, of course, but were so rare as to be considered anomalous.

Halving the mortality and morbidity rates, together with the isolation of thousands of infectious cases, have altered the situation tremendously. It is no longer an uncommon thing to find negative reactors; and this requires us to reconstruct our thinking about the tuberculin test which is a very simple and, today, a very valuable and practical diagnostic aid.

Recent studies in Minnesota showed, in a series of routine tuberculin tests of college freshmen and novitiates in nurses' training schools, 8 negative out of 10 tested. In a Wisconsin orphanage, it was interesting to observe that while over 30% of 38 girls between 6 and 21 were reactors, the only 2 girls over 18 were negative.

Tuberculin tests—like all laboratory aids to diagnosis—must be interpreted intelligently. We have not yet found a substitute for brains and judgment. But tuberculosis specialists are now, quite generally, using tuberculin as an aid to their judgment.

—H. E. D.

THE PRESIDENT'S PAGE

C. A. Harper

STATE MEDICINE—SOCIAL MEDICINE

IT IS difficult to foresee the trend of medicine. Radical changes may be remote, if at all; however, there are possibilities of relatively immediate changes in methods of procedure. Physicians should appreciate this fact, and as the process of evolution goes on, should be the directors and leaders in such changes as social conditions may necessitate.

It is not the purpose of this article to differentiate between what is generally understood as state medicine as compared with social medicine. The lines of demarcation are not well enough defined. Suffice to say that the one indicates centralization of the control of the practice of medicine, while the other tends to decentralize this particular field of activity. In view of the fact that twenty-three countries now have more or less specific government control over the practice of medicine, and seventeen countries are actively working toward socialized medicine, the question, no matter how objectionable it may appear, is one that should receive careful consideration from every active physician.

These facts alone should arouse interest on the part of every individual who is directing his energies toward the efficiency of medical practice. The discussions of these problems are so frequently observed in magazines, newspaper articles, addresses, and so forth, that the mere offering of opposition to it is not going to solve the problem. An intelligent discussion is fundamentally essential. In order to thoroughly understand the pros and cons of the whole proposition, every physician should become most familiar with the possibilities of directing the procedure should the public insist that some deviation from the present program be tried out. It behooves the medical profession, therefore, to become well acquainted with this very vital problem, and in a most understanding manner be able to direct, as far as possible, the future of general medicine. Rural districts in many localities are demanding more medical care with better hospital facilities. Every state is confronted with this problem. The people are imbued with the idea that to see the drama you go to the theatre—to become educated you go to college. Why then, if you want to be ushered to health, should you not go to a hospital? Why, when the most important thing in life is at stake, is a room in a dwelling made to suffice? Adequate hospital facilities are not afforded in many of the rural districts. Many communities that have high schools, banks, and formerly maintained from one to three physicians, are now without physicians and hospital facilities. The flocking of physicians to the larger cities, specialization and the building of hospitals in the larger communities, are no small factors in bringing about existing conditions, indicating that some form of social medicine must be developed in order to meet the wants of the general populace.

Industries, life insurance companies, and many communities are seriously discussing this phase of medicine. Sixty-two per cent of the hospital beds are now directly or indirectly under federal, state, county, or municipal control. It is estimated in Allon Peebles "Survey of Statistical Data and Medical Facilities in the United States," published in November, 1929, "that there are about 1,500,000 persons whose services are utilized by the inhabitants of the country in connection with the curing of illness, including physicians, dentists, osteopaths, chiropractors, Christian Scientists, etc." It is estimated that there are at least 200 foundations, none of which have less than $10,000,000 at their command, that are engaging in the field of health and general welfare. It is readily seen that there are tremendous forces outside of the ethical pale of the practice of medicine that are working in the field of general welfare.

These facts strongly emphasize a popular demand for certain changes that will comply, more or less, with the wishes of the general public. Is it wise for the medical profession to remain indifferent to the problem while these agencies are developing certain lines of activity, or would it not be far better for the medical profession to appreciate the evolution that is now taking place, and become a prominent factor in guiding these various lines of procedure.

At the least, it presents a problem of much study and serious thought, and the object of this article is not to champion state medicine or social medicine, but to champion scientific medicine in all its branches. It is to emphasize its importance to the welfare of the people and bring to them an appreciation of the fact that only a well-trained, properly qualified medical man can give that service which is essential for the welfare of the public as a whole.

Cornelius A. Harper, M. D., President

State Medical Society of Wisconsin, 1931

Born in the town of Hazel Green, Grant County, Wisconsin, on Feb. 20, 1864, Dr. Harper graduated at the University of Wisconsin in 1889 and received his medical degree at Columbian Medical School (now George Washington) at Washington, D. C., in 1893. Returning to Madison he began his practice on March 16, 1894.

In 1901, Dr. Harper was appointed a member of the State Board of Health by Governor La Follette and became Secretary of the Board in 1904. Re-appointed by four Governors he has served continuously as Secretary of the Board. Dr. Harper has long been a member of the State Medical Society and has served as Councilor for five years. He was given the Society's award for service in 1930.

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Vernon	W. M. Trowbridge, Viroqua	Wm. H. Remer, Chaseburg.
Walworth	E. J. Fucik, Williams Bay	S. G. Meany, East Troy.
Washington-Ozaukee	N. E. Hausmann, Kewaskum	P. M. Kauth, Slinger.
Waukesha	W. B. Campbell, Waukesha	J. F Wilkinson, Oconomowoc.
Waupaca	R. K. Irvine, Waupaca	F. J. Pfeifer, New London
Winnebago	G. V. Lynch, Oshkosh	M. C. Haines, Oshkosh.
Wood	O. N. Mortensen, Wisconsin Rapids	W. G. Sexton, Marshfield.

SOCIETY PROCEEDINGS

BARRON-WASHBURN-SAWYER-BURNETT

The Barron-Washburn-Sawyer-Burnett County Medical Society met on December second at Cumberland.

An interesting and instructive talk was given by Dr. J. B. Wear, Madison, on "Renal Infection." Dr. D. L. Dawson, Rice Lake, read a paper on "Spinal Anesthesia", which was much appreciated.

Officers for the new year were elected: President, Dr. J. H. Wallis, Rice Lake; vice-president, Dr. G. A. Larsen, Hayward; secretary and treasurer, Dr. E. R. Hering of Shell Lake.

Our colleagues in Polk County, who recently formed a separate county organization, extended cordial invitations to meet with them at some future time. E. R. H.

BROWN-KEWAUNEE

The November meeting of the Brown-Kewaunee County Medical Society was held at the Beaumont Hotel, Green Bay, Tuesday, November 25th. Dinner was served at six o'clock.

Dr. F. J. Gaenslen, past president of the State Society, was the principal speaker of the evening. His subject was "Injuries and Diseases of the Knee Joint" and was illustrated by lantern slides. The lecture was enjoyed by all and Dr. Gaenslen was given a rising vote of thanks.

Dr. D. F. Gosin, Green Bay, was admitted to membership in the society. E. S. K.

CHIPPEWA

At a meeting of the Chippewa County Medical Society, Dr. F. T. McHugh, Chippewa Falls, was reelected president and Dr. J. A. Kelly, also of Chippewa Falls, was chosen as secretary-treasurer to succeed himself.

DANE

Dr. F. J. Hodges, Madison was elected president of the Dane County Medical Society for 1931, at a meeting of the group at the Hotel Loraine on December 16th.

Dr. F. F. Bowman, Madison, was chosen vice-president and Dr. L. V. Littig, Madison, secretary-treasurer. Dr. W. D. Stovall was named chairman of the board of censors.

Dr. W. F. Lorenz, Madison, was elected delegate to the 1931 meeting of the State Society, with Dr. L. W. Peterson, Sun Prairie, as alternate.

DOUGLAS

Dr. James W. McGill, Superior, was elected president of the Douglas County Medical Society at a meeting held on December 10th in the Androy Hotel.

Other officers named were: Dr. E. E. Carpenter, vice-president; Dr. C. H. Christiansen, secretary and treasurer; Drs. L. W. Beebe, C. H. Mason and W. H. Zwickey, board of censors; Dr. T. J. O'Leary, delegate and Dr. C. W. Giesen, alternate.

EAU CLAIRE

The Eau Claire and Associated Counties Medical Society met on December 16th for the annual election of officers. Results of the election were as follows:

President, Dr. E. E. Tupper, Eau Claire; vice-president, Dr. E. P. Hayes, Eau Claire; secretary-treasurer, Dr. P. G. Spelbring, Eau Claire; censor, Dr. A. L. Payne, Eau Claire; delegates, Dr. F. C. Kinsman, Eau Claire, Dr. F. E. Butler, Menomonie; alternates, Dr. R. E. Mitchell, Eau Claire and Dr. O. J. Blosmo, Menomonie.

After the business meeting, a very fine Dutch Lunch was served at the Hotel Eau Claire. E. E. T.

GRANT

A meeting of the Grant County Medical Society was held on November 25th at Lancaster, with a program divided into two sessions.

The afternoon program, held at the Grant County Asylum, consisted of clinical demonstrations and discussions on the uses of sodium amytal, chemical constitution and pharmacology; technic of administration; use as hypnotic; use to control excitement; use in certain psychoses; use in convulsive states; value as a general anaesthetic. The entire program was presented by Doctors W. J. Bleckwenn, H. H. Reese, E. R. Schmidt and W. F. Lorenz, all of Madison.

The evening program, held in the probate court room of the county court house, covered the following subjects:

"Clinical Applications of Cerebro-Spinal Fluid Findings," by Dr. W. F. Lorenz.

"Myelography and Spinal Cord Localization" by Dr. H. H. Reese.

"Non-Surgical Considerations of Brain Injuries," by Dr. W. J. Bleckwenn.

"Surgical Aspects of Brain Injuries," by Dr. E. R. Schmidt.

Physicians were present from Shullsburg, Platteville, Argyle, Boscobel, Richland Center, Viola, Madison, Lancaster, Mineral Point, Prairie du Chien and Bloomington.

Election of officers resulted as follows: President, Dr. E. A. A. Dunn, Platteville; vice-president, Dr. C. M. Schuldt, Platteville; secretary-treasurer, Dr. M. B. Glasier, Bloomington; delegate, Dr. E. H. Spiegelberg, Boscobel; alternate, Dr. M. A. Bailey, Fennimore; censor, Dr. E. C. Howell, Fennimore. M. G. B.

IOWA

A meeting of the Iowa County Medical Society was held at St. Joseph's Hospital on December 4th at twelve noon, with a dinner served by the Sisters.

New officers were elected as follows: President, Dr. T. A. Hagerup, Dodgeville; vice-president, Dr. S. R. Ridley, Mineral Point; secretary-treasurer, Dr. H. M. Walker, Dodgeville; Censors, Drs. S. R. Ridley, T. A. Hagerup and W. J. Pearce; delegate, Dr. H. M. Walker; alternate, Dr. T. A. Hagerup.

Members present at the meeting were: Drs. D. B. Hamilton, Dodgeville; A. D. Brown, H. D. Ludden, S. R. Ridley, all of Mineral Point; Dr. W. J. Pearce, H. H. Morton, T. A. Hagerup, H. M. Walker, all of Dodgeville.

A general discussion of several interesting case reports and some of the present day problems of the general practitioner along with an excellent dinner comprised a meeting thoroughly enjoyed by all present. H. M. W.

JEFFERSON

At a meeting of the Jefferson County Medical Society held on December 11th at the Jefferson House, the following officers were elected:

President, Dr. Will Young, Fort Atkinson; vice-president, Dr. A. C. Nickles, Watertown; secretary-treasurer, Dr. M. G. Peterson, Lake Mills; delegate to state meeting, Dr. H. P. Bowen, Watertown; alternate, Dr. W. S. Waite, Watertown; censor for three years, Dr. Phillip Leicht, Lake Mills.

Two members were elected to membership in the county society, Dr. Frank Gruesen, Fort Atkinson, and Dr. D. H. Bruns, Watertown. M. G. P.

LA CROSSE

The regular meeting of the La Crosse County Medical Society was held at the La Crosse Club, November 18th, at eight p. m.

The minutes of the previous meeting were read and approved as read. The application of Dr. George D. Reay for membership to the society was approved by the censors and read before the society.

Dr. Ira Sisk, Madison, gave a very interesting talk on "The Management of the Patient with Hypertrophy of the Prostate Gland." General discussion by all members present followed.

A cafeteria lunch was served at the La Crosse Club Cafe after the meeting. R. L. E.

The December meeting of the Society was held at the La Crosse Club, on the 16th, at 8 P. M.

The minutes of the previous meeting were read and approved as read. The application of Dr. George D. Reay for membership to the Society having been read before the Society and passed by the censors at the last meeting was voted on by the members present. His membership was unanimously approved.

Correspondence from Dr. Spencer D. Beebe, Councilor, and a copy of letter by Dr. Joseph F. Smith, Wausau, to the President of the Council, was read. General discussion followed. Dr. A. J. Rosholt made a motion that the Society vote by ballot on the proposition that the La Crosse County Medical Society is in favor of the employment by the State Society of an Assistant Secretary for Mr. Crownhart. It was seconded by Dr. G. Gundersen. The motion carried by a vote of 14 in favor and 12 against it.

Dr. Gunnar Gundersen, delegate to the State Society, gave a complete report of the proceedings of the house of delegates at the 1930 State Meeting. The report was accepted.

The following officers were elected by vote of members present: President, Dr. W. J. Jones; vice-president, Dr. G. W. Lueck; secretary-treasurer, Dr. R. L. Eagan; delegate, Dr. Gunnar Gundersen; alternate, Dr. R. E. Flynn; censor for three years, Dr. A. Gundersen, all of La Crosse.

After the meeting the members retired to the La Crosse Club Cafe where a moose dinner was served. The moose was donated by Dr. W. J. Jones and was bagged by him on a recent Canadian hunting expedition. R. L. E.

MARINETTE-FLORENCE

The Marinette-Florence County Medical Society held its monthly meeting, Thursday evening, December 11th.

Dr. James C. Sargent, Milwaukee, presented a paper on "Prostatic Hypertrophy" illustrated with a motion picture.

Hon. Charles A. Budlong, read a paper on medical legislation with special reference to the needs of a tuberculous sanatorium for Marinette County. A resolution was adopted and the chair appointed Doctors Bird, Nadeau and J. W. Boren to present the subject to the county board.

A very beautiful traveling case was presented to Dr. Redelings, who leaves the first of the year for California, where he and Mrs. Redelings will spend the winter with their son, Dr. Leslie Redelings in San Diego. The gift was an expression of esteem in behalf of the Society for Dr. Redelings, who has practiced medicine in Marinette for the past forty years. He has been a leader and his influence has kept the Society on a high level and has given the association a reputation second to none in the state for its activity and good fellowship among its members. Dr. and Mrs. Edward Sawbridge of Stephenson, Michigan, and Dr. Luella Axtell of Marinette will form a party to leave New York on January 3rd and travel via Panama Canal to California.

Mr. Budlong was presented with a volume "Microbe Hunters" in recognition of his friendship and cooperation with the medical profession in their endeavor to serve the people of Wisconsin in a fitting manner and give its people high grade medical service.

A very fine dinner was served to thirty doctors and all voted the meeting was a wonderful success. M. D. B.

MILWAUKEE

A large number were on hand for the annual dinner meeting of The Medical Society of Milwaukee County which was held in the Fern Room of the Hotel Pfister on December 11. The meeting was called to order by President Ralph P. Sproule at 7:30.

The Executive Secretary made a report of the activities of the Committees during November. Dr. Sproule called attention to the mimeographed copies of the condensed report of Committee activities during 1930, which had been distributed among the members at the dinner.

Dr. Frederick Stratton, chairman of the nominating committee, presented the recommendations of his Committee. They were as follows: President-Elect, Dr. P. M. Currer; Secretary, Dr. Charles Fidler; Treasurer, Dr. J. F. Zivnuska; Director, Dr. Ralph P. Sproule; Board of Censors, Drs. Joseph Lettenberger, Wm. F. Grotjan, and Dexter Witte; Delegates to State Society, Dr. J. O. Dieterle, Dr. E. W. Miller, Dr. S. J. Seeger, Dr. H. J. Gramling, Dr H. W. Powers; Alternates to State Society, Dr. C. J. Coffey, Dr. Oscar Lotz, Dr. F. D. Murphy, Dr. H. C. Schumm, Dr. Geo. W. Neilson.

It was moved that the rules be suspended and the Secretary instructed to cast a unanimous vote for these officers. Motion was seconded and carried.

Dr. Sproule, the retiring President, gave a talk, as did Dr. E. L. Tharinger, the new President, and Dr. P. M. Currer, President-Elect.

Following the close of the business session, Dr. Edward Elliott, President of Purdue University, spoke on "The Sixth Estate."

Dr. Elliott's talk was followed by the showing of the motion picture, "The Milwaukee Medical Follies of 1930," which showed the doctors at play at the first annual picnic of the Society held at Golden Lake last June.

There were 175 present at this meeting.

OUTAGAMIE

The November meeting of the Outagamie County Medical Society was held on Tuesday, November 25th, at the Outagamie County Asylum.

The members of the Society and their wives were guests of the superintendents of the Asylum, Mr. and Mrs. Thomas Flanagan. Before the dinner the members were shown through the asylum.

The guest speaker of the evening was Dr. Phillips F. Greene, associate professor of surgery of the University of Wisconsin Medical School. His subject was "Chinese Medicine," and was very much appreciated by everyone. E. F. M.

POLK

The Polk County Medical Society was the guest of Dr. J. A. Diamond, of Frederic, on Thursday evening, November 20. A dinner was served at 7:30 by Mrs. Diamond. A friendly half hour was spent around the table after which the meeting was called to order by Dr. L. O. Simenstad, president of the Society.

A report was given by the Secretary of the disallowed claims of the Polk county physicians. This report was taken from the report of the committee on poor relief, a committee of the county board. A brief discussion followed covering the changes made by the county board in poor relief organization and administration.

Dr. Ghent, of St. Paul, read a summary of the discussions and papers given at the International Post Graduate Assembly held in Minneapolis recently. A series of interesting developments and ideas were brought out at the assembly and brought to the Polk county physicians in a brief and interesting manner. Questions were asked, special topics discussed and many practical and useful aids were gained by the Polk county physicians.

Dr. Simenstad of Osceola gave a paper on "Gastric Carcinoma", or cancer of the stomach. Each of the members were prepared to add to the discussion. The paper particularly urged the members to recognize the importance of the early diagnosis of cancer of the stomach. The members profited materially from the paper and the discussion that followed.

At the last meeting of the Polk County Medical Society at Frederic, the subject of immunization against diphtheria was discussed. In order that the toxin-antitoxin might be available to the children in the schools the physicians decided that where a school board felt the need and realized the value of the administration of toxin-antitoxin they, the physicians, would make the financial part of the immunization extremely reasonable. Where the children are grouped together under one roof and all of them assembled at one time the physician would be able to take care of a greater number in a given time, he could also secure the toxin-antitoxin at a reduced figure in quantities. The physicians felt that the immunization was so important that they would do this work for a charge of one dollar for each child, providing the group contained ten or more. This would include all three inoculations and the furnishing of the medicine. The smallpox question was also discussed. A charge of fifty cents was decided upon as being very nominal and well within the reach of every school board. If re-vaccination be found necessary an additional charge of fifty cents would be made. For schools having only a small number and living at a distance from the physician's office a mileage charge would be made. However, if the group be brought to the physician's office at one time they would be able to have the three inoculations for one dollar. This is only a small expression of the great tendency of the medical profession toward the prevention of disease rather than the cure of disease. The medical profession is anxious and willing to cooperate with the public to minimize sickness and disease in the public systems.

The widespread use of smallpox vaccine has reduced the number of smallpox epidemics and cases. Diphtheria can be held in check with equal success if the general public will realize the need and value of inoculations to prevent diphtheria.

ROCK

Upwards of one hundred and thirty persons attended the annual Thanksgiving clinic and party which was held in Pinehurst Sanatorium, Janesville, on Tuesday afternoon and evening, November 25th.

During the afternoon the physicians participated in a neurological clinic which was conducted by Dr. George W. Hall of Chicago.

Dr. F. A. Thayer of Beloit, presided at the Thanksgiving dinner which was served at six thirty o'clock. Miss Charlotte Chamberlain of Beloit entertained the gathering with piano and whistling numbers and a "chalk talk." The remainder of the evening was spent in dancing.

SHEBOYGAN

About forty members of the Sheboygan County Medical Society and guests from Kiel, New Holstein, Chilton, Beaver Dam and Milwaukee, responded to the annual invitation of the Rocky Knoll Sanatorium and there enjoyed a bountiful dinner on November 20th. Our hearty thanks to you, Miss Dietrichsen, and the trustees.

Previous to the dinner, Dr. R. C. Meyer, medical director of the Sanatorium, showing some interesting x-ray films and discussed their case histories.

After the dinner, Dr. A. W. Gray of Milwaukee read a paper on "Pneumonoconiosis." It was an excellent presentation of an interesting although neglected subject and it elicited a lively discussion.

The next subject "Modes of Onset of Tuberculosis" by Dr. Oscar Lotz of Milwaukee might have been entitled "Confessions of a Tuberculosis Specialist." I wish everyone could hear the lessons taught. Both speakers and subjects deserve a larger audience, although I am sure they could not find a more appreciative one.

Dr. Herman A. Feiker of Sheboygan and Dr. John W. Hess of Adell were elected to membership. The old officers were re-elected for the coming year with the addition of Dr. C. J. Weber, Sheboygan, as alternate delegate.

Those invited who did not attend missed a real, lively meeting. A. C. R.

TREMPEALEAU-JACKSON-BUFFALO

A dinner meeting of the Trempealeau-Jackson-Buffalo County Medical Society was held at Galesville on December 4th.

The following officers were elected: President, Dr. J. W. Lowe, Merrillan; vice-president, Dr. R. L. Alverez, Galesville; secretary-treasurer, Dr. R. L. MacCornack, Whitehall; delegate, Dr. C. F. Peterson, Independence and alternate, Dr. H. A. Jegi, Galesville.

Dinner was served to the members of the Society at the public school building and was followed by their business session. Speakers at the meeting included Dr. F. T. Weber, Arcadia; Dr. C. O. Rogne, Ettrick; Dr. J. P. Reinhardt, Fountain City and Dr. Chauncey D. Beebe of Sparta.

VERNON

The Vernon County Medical Society held its annual meeting in the Farmers Bank Building, Viroqua on December 17th at seven-thirty p. m.

The following officers were elected for 1931: president, Dr. W. M. Trowbridge, Viroqua; vice-president, Dr. C. E. Lauder, Viroqua; secretary-treasurer, Dr. W. H. Remer, Chaseburg; delegate, Dr. W. H. Remer, Chaseburg; alternate, Dr. P. H. Hansberry, Hillsboro; censor for three years, Dr. J. Schee, Westby.

Dr. R. H. Ludden, Viroqua, read a very excellent paper on "Cervicitis."

We feel that we have had some very good meetings this year and some wonderful material has been presented to the Society by the men who have so graciously given us of their time and talents. Our greatest regret lies in the fact that those members who failed to attend the meetings missed all of that good material. We are sure that if they could be acquainted with what they are missing, that attendance at the meetings would be greatly stimulated. W. H. R.

WALWORTH

Dr. E. J. Fucik, Williams Bay, was elected president of the Walworth County Medical Society at a meeting of the group held in Delavan. Other officers elected were: Dr. R. A. Mullin, East Troy, vice-president; Dr. S. G. Meany, East Troy, secretary; Dr. R. C. Halsey, Lake Geneva, censor; Dr. R. LeRoy Jacobson, Delavan, delegate.

WINNEBAGO

The monthly meeting of the Winnebago County Medical Society was held at the residence of Dr. L. O. Helmes, 84 Jefferson Avenue, Oshkosh, on November 21st.

After a short session, Mr. George Crownhart, secretary of the State Society, delivered an address on "The Woman's Auxiliary as an Aid to the State Medical Society." A discussion followed during which the members of the society presented their views on the subject although no action was taken to organize an auxiliary at the present time.

Dr. A. C. Gifford addressed the Society on "Etiology and Diagnosis of Malformations of the Mouth and Face", illustrated with stereopticon views. His subject was very interesting and nicely presented.

After adjournment an appropriate lunch was served by Mrs. Helmes.

The Society met again on December 19th in the Staff Room of Mercy Hospital, Oshkosh, to elect officers for 1931. The following men were elected:

President, Dr. G. V. Lynch, Oshkosh; vice-president, Dr. G. E. Forkin, Menasha; secretary-treasurer, Dr. M. C. Haines, Oshkosh; censor, Dr. R. H. Bitter, Oshkosh; delegate, Dr. J. W. Lockhart, Oshkosh; alternate, Dr. R. B. Rogers, Neenah.

Dr. E. L. Sevringhaus of Madison gave an instructive and interesting talk on "A Simple Plan for the Treatment of Diabetes Outside a Hospital." A general discussion followed after which a luncheon was served. M. C. H.

INTERURBAN ACADEMY OF MEDICINE

Dr. James W. McGill, Superior, was named vice-president and Dr. T. J. O'Leary was named censor of the Interurban Academy of Medicine, an organization of Superior and Duluth physicians, at a meeting held at the Androy Hotel, Superior, on November 19th. Dr. George L. Berdez, Duluth, was elected president and Dr. R. J. Moe, also of Duluth, secretary.

More than sixty physicians from the two cities were in attendance. Dr. Louis M. Warfield, Milwaukee, was the principal speaker of the evening.

The Academy, founded in 1894, has seven of its twenty-five charter members still active. They are: Drs. John Baird, P. G. McGill, W. E. Ground, H. J. Orchard, George Saunders of Superior, and Drs. S. H. Boyer and C. F. McComb of Duluth.

The January meeting will be held in Duluth.

MILWAUKEE ACADEMY OF MEDICINE

Members of the Milwaukee Academy of Medicine met on Tuesday, November 25th. A scientific meeting was held at 8:15 p. m., and the following papers were presented:

Case Report—Progressive Muscular Atrophy, illustrated with moving pictures by Drs. John L. Garvey and T. L. Squier.

Management of Rectal Abscesses and Ano-Rectal Fistulae by Dr. A. W. Johnson.

Medicine and Criminal Justice by Dr. Oscar T. Schultz, director of laboratories, St. Francis Hospital, Evanston, and Columbia Hospital, Milwaukee.

The December meeting was held on Tuesday evening, December 9th.

Dr. Eben J. Carey, Milwaukee, presented a paper on "The Etiology of Pathological Bone Growth" and Dr. Hugh Cabot of the Mayo Clinic, Rochester, addressed the group on the subject of "What Constitutes Real Conservative Surgery of the Kidney."

Another meeting of the Academy was held at the Wisconsin Club on the 16th with a dinner at six-thirty. The following program was presented:

1. "Pulsation Exophthalmos with Retrobulbar Hematoma," by Dr. E. Bach.
2. "Cavernous Sinus Thrombosis with Recovery" by Dr. R. J. Muenzner.
3. "Osteoma of the External Auditory Canal with Dry Cholesteatoma" by W. E. Grove.
4. "Concentric Contraction of the Visual Fields" by Dr. E. R. Ryan.

MILWAUKEE OTO-OPHTHALMIC

The November meeting of the Milwaukee Oto-Ophthalmic Society took place at the Wisconsin Club on Tuesday, the 18th.

The meeting was called to order following a dinner which was served at six thirty o'clock. Dr. C. Zimmermann and Dr. W. H. Halsey, related their impressions of the work and conditions in the various clinics and medical centers they visited during the past year. Dr. H. F. Wolters abstracted the proceedings of the German Otological Society and read a resume of the treatment of otitis interna.

MILWAUKEE INTERNISTS

The Milwaukee Internists Club held a luncheon meeting at the University Club on December 18th.

NINTH COUNCILOR DISTRICT

The autumn meeting of the Ninth Councilor District Medical Society was held at the Wausau Club, Wausau, November 20th.

The meeting opened at four p. m., with a pediatric clinic held at St. Mary's Hospital. At six o'clock dinner was served at the Wausau Club, after which the following program was given:

"The Salt-Free Diet of Treatment of Tuberculosis by Dr. Karl W. Doege of the Marshfield Clinic.

"Convalescent Serum Therapy" by Dr. J. E. Gonce of the Wisconsin General Hospital, Madison.

"The Relation of the Laboratory to Clinical Medicine" by Dr. W. D. Stovall, director of State Laboratory of Hygiene, Madison.

UNIVERSITY OF WISCONSIN

Dr. John Stanley Coulter, associate professor of physical therapy, Northwestern University, addressed a meeting of the University of Wisconsin Medical Society on November 21st in the Service Memorial Institute, at eight p. m. The subject of his address was "Physical Therapy in General Practice" and was illustrated by moving pictures.

At the December meeting of the Society held on the 11th, the following addresses were given: "The Romance of Surgery" by Dr. Victor F. Marshall of Appleton and "Extracts From Chinese Anatomy and Physiology" by Dr. Phillips F. Greene, which was illustrated by lantern slides.

COUNCIL

Proceedings of the January meeting of the Council of the State Medical Society will be published in full in the February issue of the Journal. The Council met for a full day session on Saturday, January 3rd, at the University Club, Milwaukee.

NEWS ITEMS AND PERSONALS

Dr. W. J. Miller, of the State Board of Health, Madison, spoke on "Health of Men of Forty-five" before a meeting of the Kiwanis Club of Baraboo.

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An appropriation of $1,000 was voted by the Brown County board of supervisors on November 18th for the purpose of carrying on a campaign for the prevention of diphtheria among the children of the county.

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Dr. J. R. Harvey, Footville, served as toastmaster at the father and son banquet held at the high school on December 10th.

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Dr. G. C. Waufle of Janesville, who has been ill for several weeks, is spending a few weeks recuperating in Florida.

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Dr. C. J. Moran, La Crosse, has moved his office from the Security Bank Building to fourth floor of the Hoeschler Building.

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A person licensed by the State Board of Medical Examiners to practice osteopathy and surgery is not authorized thereby to write liquor prescriptions for medical purposes, the attorney general ruled recently. An osteopath is not a physician within the meaning of the statutes, the ruling said.

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Dr. W. C. Comee, Green Bay, attended the meeting of the Central Wisconsin Ophthalmological and Oto-Laryngological Society at Chicago.

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Dr. P. L. Edwards, a graduate of the Medical School, University of Wisconsin, 1929, is assisting for several months at the Post, Coleman and Schlomovitz Clinic at Barron.

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Dr. L. H. Crane, formerly of Menasha, has opened an office in Manawa.

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The salary of the county physician of Outagamie county was increased from $1,000 per year to $1,200.

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Dr. R. H. Jackson, Madison, presented a paper before a meeting on December 5th, of the Western Surgical Association at Kansas City, Mo., on "The Benefits Conferred by Spinal Anesthesia Upon Patient and Surgeon." Dr. A. S. Jackson, Madison, also attended the meeting.

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The cornerstone of the new Memorial Hospital at New London was laid on November 21st. Drs. A. C. and M. A. Borchardt participated in the ceremony.

Dr. F. S. Cook and Dr. P. G. Spelbring, Eau Claire, have removed their offices to the new Union National Bank Building.

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Governor and Mrs. Walter J. Kohler were guests of honor at a dinner given by Dr. and Mrs. R. C. Buerki, Madison, on Saturday, December 20th.

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Dr. E. J. Campbell, City Health Commissioner of Oshkosh, spoke on the subject of health at a meeting of the Young Men's club of Zion Lutheran church.

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Dr. C. E. Garner, formerly of Livingston, has opened an office in Boaz, Wisconsin.

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A moose dinner given by Dr. W. J. Jones for doctors of the staff and the directors and their wives featured the annual meeting of La Crosse Methodist Hospital on December 9th. Dr. Jones accompanied a friend on a hunting trip in Canada and each returned with a moose.

Following the dinner, officers were elected. Dr. J. E. Heraty was chosen president, Dr. L. W. Eidam, vice-president, Dr. Robert H. Gray, secretary and treasurer, Dr. Henry Jegi of Galesville and Dr. George R. Reay of La Crosse, members of the advisory board.

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Dr. W. J. Miller, Madison, was a speaker at the December luncheon meeting of the La Crosse County Community Council. His topic was "Preventive Medicine."

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Dr. E. A. Pohle, professor of radiology, University of Wisconsin, returned from Los Angeles where he attended the Sixteenth Annual Meeting of the Radiological Society of North America, held at the Ambassador Hotel, December 1–5. Dr. Pohle was leader of a symposium on physical therapy, with Drs. W. S. Peck, Ann Arbor, W. Stenstrom, Minneapolis, and J. S. Coulter, Chicago, participating. In addition to this, Dr. Pohle presented a paper on "The Effect of Roentgen Rays on the Healing of Wounds" which was based on experimental work carried out with Drs. G. Ritchie and C. S. Wright of Madison.

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Dr. Damon A. Brown, Madison, announced recently the re-opening of his offices at 14 East Mifflin Street, Madison.

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According to a War Department announcement, Dr. W. A. Werrell, Madison, has accepted appointment as a captain in the medical reserve corps.

Alcoholism claimed 113 Wisconsin lives in 1929 to mark the highest death rate from this cause in the history of the state, it was announced by the Bureau of Vital Statistics of the State Board of Health.

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Dr. C. F. Dull of Drs. Coumbe, Dull and Lowe, Richland Center, with wife and son, was in Boston during the month of November, where he took a course in clinical surgery at the Massachusetts General Hospital and two weeks operative surgery at the Post Graduate School of Surgical Technique at Chicago.

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Mrs. L. D. A. Winn, Portage, wife of Dr. L. D. A. Winn died on December 10th following a short illness.

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A bronze relief placque, in recognition of the long services of Dr. Walter E. Meanwell, basketball coach, University of Wisconsin, was unveiled at the dedication ceremonies of Wisconsin's new field house on December 18th. The placque is the work of Mrs. Julian E. Harris, wife of Prof. Julian E. Harris of the French department, University of Wisconsin.

Dr. Carl Harper, Madison, was chairman of the Meanwell testimonial committee.

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A Christmas dinner for Watertown physicians and members of the board of directors of St. Mary's Hospital, Watertown, was given on December 16th by the Sisters of the Hospital. Addresses were made by Drs. H. P. Bowen of Watertown and F. A. Eickelberg of Reeseville.

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Dr. and Mrs. T. J. Redelings of Marinette left on January 3rd for California via Panama Canal where they will spend the winter with their son, Dr. Leslie Redelings in San Diego.

Dr. Luella Axtell, Marinette, with Dr. and Mrs. Edward Sawbridge of Stephenson, Michigan, also left on January 3rd for California by the same route.

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Dr. Harry B. Moe of Chicago has joined the Munn-Farnsworth Clinic at Janesville where he will have charge of the eye, ear, nose and throat department.

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Dr. Merritt L. Jones, Wausau, addressed the Eighth District Nurses Society on November 17. The subject of his address was "Quacks and Quackery."

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Dr. Louis M. Warfield, Milwaukee, addressed a meeting of the Rotary Club of Kenosha at the Elks Club. The subject of his address was "Diseases of the Heart." Dr. Warfield was introduced by Dr. George F. Adams of Kenosha.

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Dr. J. W. Lockhart, Oshkosh, was re-elected county physician of Winnebago County.

ANNUAL MEETING

Suggestions for the program of the 90th anniversary meeting of the State Society to be held at Madison in September will be welcomed. Address Dr. Arthur G. Sullivan, Gay Building, Madison, Wis.

Dr. R. L. Cowles of Green Bay reported to police the theft of his Buick coupe on November 18th.

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Surgical instruments and a case containing narcotics were stolen from the car owned by Dr. F. J. Woodhead of Wauksha while parked on Detroit street, Milwaukee, on November 18th.

MILWAUKEE

Dr. S. N. Franklin left for Europe on December 8.

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Dr. Harry Foerster, who has been ill with pneumonia is much improved. He left for an extended vacation in Florida on December 7.

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Dr. John P. Koehler, Health Commissioner of Milwaukee, spoke to the health division of the Central Council of Social Agencies on December 5. He urged an intensive campaign during January in the interest of periodic health examinations and asked the cooperation of the medical profession and the hospitals.

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A staff meeting was held at the Muirdale Sanatorium on December 3. Dr. R. P. Tully presented a paper on, "Asthma and Pulmonary Tuberculosis."

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A meeting of the Physicians Service Bureau advisory committee of the Medical Society of Milwaukee County was held on November 19. Policies of the Bureau were discussed at some length. Particular attention was given to the request of business concerns to be served by the Bureau.

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Dr. D. W. Roberts appeared for the speakers bureau of The Medical Society of Milwaukee County at a meeting of the Knights of the Round Table at the Hotel Wisconsin on December 10. His subject was "How is your Health?"

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Mr. Theodore Wiprud, executive secretary of The Medical Society of Milwaukee County spoke to the Exchange Club at a noon luncheon meeting on December 18.

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The following radio talks sponsored by the State Board of Health were given by Theodore Wiprud, executive secretary of The Medical Society of Milwaukee County over the Milwaukee Journal Station WTMJ during December:

Dec. 1. "Why More Deaths During Winter Months."
Dec. 8. "Heart Disease."
Dec. 15. "The Fight Against Tuberculosis."
Dec. 22. "The Prolongation of Life."
Dec. 29. "Are All Auto Accidents Accidental?"

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A large and enthusiastic group greeted Dr. Morris Fishbein, editor of the Journal of the American Medical Association, at the first session of the course in medical writing sponsored by the University Extension Division in cooperation with the Medical Society of Milwaukee County on December 3. Forty-three are enrolled for this course. There will be six sessions. Those who have enrolled to date are as follows: Drs. F. D. Murphy, S. J. Seeger, M. Fernan-Nunez, Joseph J. Eisenberg, Herbert W. Powers, E. L. Tharinger, John E. Rueth. J. E. Mulsow, R. W. Blumenthal, Francis J. Stirn, B. Warshauer, H. G. Schmidt, Paul M. Currer, Jeffry J. Brook, G. H. Fellman, H. C. Ladewig, O. P. Schoofs, Alfred W. Gray, H. B. Miner, F. R. Janney, Millard Tufts, R. P. Schowalter, J. Adamkiewicz, Ralph P. Sproule, N. E. McBeath, S. M. Markson, Eleanore Cushing-Lippitt, John M. Gulas, John M. Powers, Ray J. Dalton, Eben J. Carey, H. W. Shutter, M. H. Boley, R. A. Gilfry, H. J. Gramling, H. P. Haushalter, D. W. Roberts, W. J. Carson, W. T. Kradwell, S. E. Kohn, Merle Q. Howard, G. F. Mueller, S. M. Turkeltaub.

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A meeting of the public health advisory committee of The Medical Society of Milwaukee County was held at the Johnston Emergency Hospital on December 4. This committee meets monthly with Dr. John P. Koehler, Commissioner of Health, to discuss activities of the health department which affect the medical profession. A number of matters relating to public health were brought up at this session.

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A meeting of the board of directors of The Medical Society of Milwaukee County was held on November 28. At this session the invitation of Dr. Harry Sargeant, Superintendent of the County Hospital, to the Society to hold its January meeting in the new County Hospital was accepted. Further consideration was also given to the collection service which is to be inaugurated about January 1.

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The legislative committee of The Medical Society of Milwaukee County met in joint session with the legislative committees of the State Medical Society and the State Board of Medical Examiners at the University Club on December 7. Legislation affecting public health was discussed. Members of the legislative committee of The Medical Society of Milwaukee County are: Dr. Gilbert Seaman, Chairman, Doctors Dexter Witte and A. W. Gray.

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Dr. S. Plahner, addressed the monthly meeting of the Washington School Parent-Teacher's Association, Wauwatosa, on December 3rd. The subject was "Why do we Need Psychological Advice in School and at Home?"

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Dr. Karl E. Kassowitz addressed the Lions Club on November 10th, and the Club of Registered Nurses, both of Milwaukee, on the 2nd of December. The subject of both talks was "New Aspects of Prevention and Treatment of Tuberculosis."

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The $300,000 estate left by the late Dr. Frank B. Golley of Milwaukee, medical director of the Old Line Life Insurance Company and former head of the Johnston Emergency hospital, will be shared by his widow and three sons.

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Dr. R. E. Bushong spoke on Wisconsin's Penal Institutions before a meeting of the Whitefish Bay Woman's Club.

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Dr. F. B. McMahon addressed the graduate nurses in the health service training school of the Wisconsin Anti-Tuberculosis Association on the subject of "Cancer."

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The Wisconsin Parent-Teacher, official bulletin of the state congress of parents and teachers, contains an article by Dr. Elisabeth Seiler, former Kenosha school physician, on "Rewards and Punishments."

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Dr. Louis M. Warfield addressed thirty-five members of the Rotary Club of Ripon at a weekly session. The program was in charge of Dr. J. M. Johnson, Ripon, who introduced the speaker.

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A testimonial dinner was tendered to Mr. J. S. Janssen by the medical profession of Milwaukee County on December 17th, at the Schroeder Hotel. Mr. Jannsen is a pioneer in the x-ray field in Milwaukee, having served the Milwaukee Hospital for many years. He owned one of the first x-ray apparatuses in the city.

Among the speakers were Doctors Gilbert E. Seaman, F. W. Mackoy, C. A. Harper, and R. W. Blumenthal. Dr. A. T. Holbrook was toastmaster.

The Arrangement Committee was as follows: Drs. E. A. Fletcher, H. B. Podlasky, Louis Fuerstenau, Stephen Cahana, Francis Murphy, A. J. Patek, Joseph Carroll, A. T. Holbrook, S. J. Seeger, and R. W. Blumenthal.

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According to the report of the Milwaukee Health Department, Milwaukee enjoyed a more healthful year during 1930 than during 1929. The death rate dropped to 9.6 a thousand as compared with 10.5 last year. There were 474 fewer deaths, the 1930 total being 5,633. Births fell off. The year's total of living births was 11,515 which was 719 less than in 1929.

There were fewer deaths among infants under one year old, the rate for 1930 being 56 as against 72

last year. Diseases generally decreased, except infantile paralysis and cancer.

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The Medical Society of Milwaukee County is providing free medical service at the Goodfellow House, a home for homeless and unemployed men sponsored by the Milwaukee Journal. Members take turns and spend an hour at the Goodfellow House each day. They examine all newcomers for contagious disease. Those who require treatment are referred to the county institutions.

Dr. R. W. Blumenthal, chairman of the educational committee of the society, is in charge. Those who are serving during December are: Doctors P. M. Currer, W. P. O'Malley, Richard D. Champney, Maurice Olsen, J. W. Fons, Chester Long, J. A. Murphy, Harvey Webb, John A. Grab, C. T. Clauson, J. B. Ozonoff, Ralph Garens, Wm. A. Ryan, J. W. Smith. The Journal expects to operate the Goodfellow House until about May 1.

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The net value of the estate of Dr. Ernst J. Copeland of Milwaukee who died September 10, 1929, is $245,800.00. This was revealed at a final hearing in Judge Sherdian's Court on December 16. Of the estate $70,000 is to go to the Layton Art Gallery, $70,000 to the endowment fund of the Columbia Hospital Nurses Training School, and $70,000 in trust to Dr. Copeland's brother Clyde at Monroe, Wisconsin. After the brother dies the $70,000 is to go to a niece and two nephews of Dr. Copeland's. Major Howard Greene is executor of the estate.

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Dr. A. L. Banyai presented a paper on "Pneuoperitoneum in the treatment of tuberculous enterocolitis," at a meeting of the staff of Muirdale Sanatorium on December 17th in Milwaukee.

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Rev. Bruno Howe, superintendent of Evangelical Deaconess Hospital of Milwaukee died following a heart attack on December 10. Rev. Howe was 55 years old and had served as superintendent of the Deaconess Hospital since April, 1921. During that time the hospital increased from 50 to 180 beds.

Rev. Howe was born in Bremen, Germany, coming to this country in 1901. Until he was called to Milwaukee in 1921 he served a pastorate at Danville, Illinois. Rev. Howe was also President of the Northern Illinois District of the Evangelical Synod of North America, and Second Vice President of the Steuben Society.

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A meeting was held at the University Club of Milwaukee on Monday December 15, to make plans for the coming of the Inter-State Postgraduate Medical Association next October. Dr. Ralph P. Sproule, president of The Medical Society of Milwaukee County, acted as chairman. Following preliminary discussion Dr. Sproule was elected executive chairman for Milwaukee for the coming session of the Association. The executive committee will hold a session immediately after the first of the year to make definite plans.

The executive committee includes the following: Dr. Ralph P. Sproule, chairman; Dr. G. A. Carhart, vice chairman; Dr. J. Gurney Taylor, vice chairman; Earl Ferguson, secretary Convention Bureau, Milwaukee Association of Commerce; Joseph Grieb, manager, Auditorium; Howard L. Ashworth, secretary Milwaukee Hotel Association; W. L. Coffey, manager of County Institutions; Dr. Harry Sargeant, superintendent of County Hospital; Dr. E. A. Smith, director, The Milwaukee County Dispensary; Dr. E. L. Tharinger, president, The Medical Society of Milwaukee County; Dr. G. V. I. Brown, Dr. Edwin Henes, Jr., Dr. A. W. Rogers, Dr. J. P. McMahon, Dr. D. E. W. Wenstrand, Theodore Wiprud, executive secretary, The Medical Society of Milwaukee County; Dr O. R. Lillie, Dr. P. M. Currer, Dr. Rock Sleyster, Dr. Henry J. Gramling, Dr. Charles Fidler, Dr. Ralph E. Morter, Dr. A. W. Gray, Dr. C. H. Stoddard, Dr. R. W. Blumenthal, Dr. Carl W. Eberbach, Dr. Carl Henry Davis, Dr. Chester M. Echols, Dr. Arthur T. Holbrook, Dr. Roland S. Cron, Dr. S. J. Seeger, Dr. John L. Yates, Dr. J. Foster McNary, Dr. E. J. Carey, Dr. E. W. Miller, Dr. F. A. Stratton, Dr. F. D. Murphy, Dr. Joseph King, and Dr. Millard Tufts.

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The board of directors of The Medical Society of Milwaukee County held its meeting at the executive offices on December 12. The January meeting of the society which will be held at the County Hospital, was discussed.

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It was announced on December 17 that the Milwaukee Hospital will build an addition at a cost of $400,000. The plans are being pushed so that work can be started at once. The addition will replace the original hospital building which will be torn down. Preliminary plans have been presented by Clas & Clas, Architects, and are now being studied by the building committee.

It is expected that plans will be completed early in February so that bids can be obtained by the end of February and work started March 1.

Members of the committee are: Fred J. Schroeder, Chairman, Rev. Fritschel, Charles K. Ilsley, Cyrus Phillip, and Sister Catherine. The new building will be six stories high and will have about 100 beds, the latest in hospital equipment and design.

Rev. Herman L. Fritschel is Superintendent of Milwaukee Hospital.

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Dr. S. J. Seeger of Milwaukee spent the holidays in Texas.

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The Physicians' Service Bureau Advisory Committee of the Medical Society of Milwaukee County held a meeting at the executive offices on December 16. The meeting was given over to the examination of records of calls handled by the Bureau

from November 1, 1929, to December 1, 1930. A total of 52,000 incoming and outgoing calls were handled by the Bureau during this period.

BIRTHS

A son to Dr. and Mrs. Norbert Enzer of Milwaukee on November 26.

ENGAGEMENTS

Dr. Alphons E. Bachhuber, Jr., Mayville to Miss Monona Nickles, Madison.

DEATHS

Dr. Frederick Schneider, New London, died on November 24th at his home after a week's illness.

Dr. Schneider was born May 16, 1880, at Boenstadt, province of Hesse, Germany. He received his education and was trained for the ministry at Freiburg, Germany. In 1868 he came to America and entered Concordia College, St. Louis, completing a course in medical missionary work in 1870. Following this he moved to Wisconsin and established a settlement, which he later named Concord. He served parishes at Waterford, East Troy, Brillion and Reedsville. In 1880, Dr. Schneider went to Germany to continue his medical studies. On returning to America, he settled at Wittenberg. In 1890, Dr. Schneider gave up his work as missionary and thereafter devoted his entire time to the medical profession. Since 1905, he had practiced medicine in New London.

He was a member of Waupaca County Medical Society, the State Medical Society and the American Medical Association.

He is survivied by his widow and one daughter.

Dr. W. A. Shepherd, Seymour, died on November 23rd at a Green Bay Hospital after a short illness.

He was born in 1875, and received his medical degree from the University of Illinois in 1903. He practiced medicine in Seymour for many years.

Dr. Shepherd was a member of Outagamie County Medical Society, the State Medical Society and the American Medical Association.

He is survived by his widow and one son.

Dr. Frank B. Golley, Milwaukee, died on November 29th at Nashotah, Wisconsin. He had been ill for several weeks. Dr. Golley, who was 75 years of age, had practiced in Milwaukee for nearly 50 years. For a number of years he had been in charge at Johnston Emergency Hospital. He came here from the state of New York, where he was born, when he was 23 years old. He was a member of the Old Settlers' Club of Milwaukee.

Dr. Golley was a member of the Medical Society of Milwaukee County, the State Medical Society and the American Medical Association.

He is survived by his widow and three sons.

Dr. George H. Gates, Milwaukee, died on December 14th at his home.

Dr. Gates was born in 1865. He attended General Medical College, Chicago, graduating in 1889, and began a practice in East Troy, Wisconsin. A few years later he moved to Rochester. For the past ten years he had been a physician in Milwaukee.

Surviving Dr. Gates are his widow, a daughter and two sons.

SOCIETY RECORDS

New Members

Harold A. O'Brien, Marinette, Wis.

Luis F. Gonzales, Glidden, Wis.

Alfred J. Roach, Pureair Sanatorium, Bayfield, Wis.

Louis A. Eisenberg, 2048—27th St., Milwaukee, Wis.

P. J. Gilmer, 906 Vliet St., Milwaukee, Wis.

D. J. Gardetto, 339 Delaware Ave., Milwaukee, Wis.

Changes in Address

Dr. H. B. Moe, Chicago to 1015 Racine St., Janesville, Wis.

Dr. F. A. Ware, Boscobel to 1012 Vermilya Ave., Flint, Mich.

» » » CORRESPONDENCE « « «

"GREATEST HONORS"

THE WEST VIRGINIA MEDICAL JOURNAL
Wheeling, West Virginia
December 19, 1930.

Mr. George Crownhart,
Secretary,
Wisconsin Medical Journal,
Madison, Wisconsin.

Dear Mr. Crownhart:

May I express to you and the Journal you represent my great appreciation of what I consider to be one of the greatest honors in the entire medical world—appearing on the front cover? To have said something that was worth going on that valuable space in your very admirable and forward looking periodical fills me with deep humility.

Thanking you, I am

Gratefully,

HARRY M. HALL.

STATE MEDICINE

Appleton, Wis., Nov. 27, 1930.

Mr. George Crownhart,
Sec. of State Medical Society,
Madison, Wis.

My dear Mr. Crownhart:

I am a student at Lawrence College. The question for the girl's debate squad this year is: Resolved, that State Medicine should be adopted.

It has been suggested that I write to you for valuable material on State Medicine.

Although I am on the affirmative team, and would naturally be glad to get material in favor of State Medicine, I would welcome any material you might have—pro or con—on this subject.

Thanking you kindly in advance, I remain

Sincerely yours,

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HEALTH INSURANCE

NATIONAL BUREAU OF ECONOMIC RESEARCH, INC.

A non-profit membership corporation for impartial investigations in the field of Economic, and Industrial Science

———

Executive Offices and Statistical Laboratory
51 Madison Avenue, New York
Madison Square

December 9, 1930.

Mr. J. G. Crownhart, Secretary,
State Medical Society of Wisconsin,
119 East Washington Avenue,
Madison, Wisconsin.

My dear Mr. Crownhart:

At the request of the Committee on the Costs of Medical Care, Washington, D. C., the National Bureau of Economic Research is gathering some information regarding organized plans for providing medical care on an insurance or contract basis. Of course, we have access to a great amount of published data regarding health and accident insurance as written by commercial and fraternal organizations, but we are not primarily concerned with insurance plans which pay a cash indemnity during the period of disablement from sickness, but rather with schemes under which, in return for payment of a fixed fee, the contract holder becomes entitled to medical service as such. As you of course know, there are, in various sections of the country, corporations organized for the purpose of rendering such contract medical service. Sometimes the service is limited to that which a general medical practitioner can furnish in his own offices; sometimes, however, the contract includes hospital service. Where such corporations exist, they usually enter into arrangements with physicians to furnish contract holders a certain type of medical service. The doctor receives his remuneration from the medical service corporation on a fixed schedule basis. Where the corporation provides hospital service it usually has a fixed schedule of ward rates in local hospitals.

We have heard of one or two group clinics and general hospitals which are offering a contract medical service.

At the recent meeting of the Committee on the Costs of Medical Care, in Washington, I discussed this phase of our study with Dr. Olin West, Secretary and General Manager of the American Medical Association. Dr. West suggested that I write the secretaries of the different state medical associations for information.

We do not wish to burden you in this matter, but if you could give us some information as to contract medical service in your state, it would be a real contribution to our study. The questions to which we should like to have specific answers are the following:

1. Do you know of any hospitals or group clinics in your state that are offering medical service to individuals or to employers (for the benefit of their employees) on a contract basis? The essence of the contract is, of course, an agreement on the part of the hospital or clinic to furnish a certain type of service during a stipulated period of time in return for a fixed fee paid by the contract holder.

2. Do you know of any corporations or associations offering such service and arranging with medical practitioners and hospitals to give the medical service?

If you do know of any such clinics or corporations and could let us have the names and addresses so that we could write direct for further information, we should greatly appreciate it.

Yours very truly,
(Signed) PIERCE WILLIAMS,
Executive Director.

THE SECRETARY'S SALARY

December 15, 1930, Sparta, Wis.

La Crosse County Medical Society,
La Crosse, Wis.

Dear Friends:

I am asking your Secretary to read you a letter to the members of the Council, from Dr. Joseph Smith of Wausau, regarding the matter of employing an Assistant Secretary for the State Medical Society.

The latter amply explains the matter under debate. There are probably at least two good sides to this quetsion and I would appreciate the reaction of the members of the La Crosse County to this matter.

For your information let me state that our Secretary, Mr. Crownhart, has now an income of $8,000 per annum for his services to the State Society and to the State Medical Journal. He has a straight salary of $6800.00 from the State Medical Society. In addition to that he receives annually $1200.00 from the State Society for his services as Editor and Manager of the Journal. This makes an an-

nual income of $8,000. Of course, he also has his office rent and traveling expenses furnished him. That goes without saying.

The foregoing figures are given you, not in criticism, but, as a bit of information which needs to be disseminated among the members of our component societies to the end that we may all know more definitely the manner in which our Society is functioning.

You will want your Councilor to keep an open mind upon this subject. Neither side of the problem has been adequately presented.

However, I would appreciate it if any of you or all of you would write me your reaction to the matter.

Personally, I know of no good reason why Mr. Crownhart's salary should not be put down in our budget as $8000.00 instead of charging $6800.00 up to salary and $1200.00 of it up to the Journal which really is the State Society's project.[1] In a rather wide acquaintance with the members over the entire state I have yet to meet an unofficial member who knew that our Secretary was receiving more than $6800.00 from his connection with our State Society.[2]

The membership is entitled to know the total amount of the Secretary's income from his connection with us since it has a very distinct bearing upon the question as to whether or not we can afford to go out, now, and hire an assistant secretary.

I trust that nothing in this letter will be construed as a criticism of the amount of salary our Secretary is receiving. As a matter of fact he has been offered more elsewhere.

I think it is generally conceded that Mr. Crownhart ranks well up among the most efficient Secretaries of the whole country. We are not, therefore, debating whether his services to us are commensurate with his salary. Rather, we are going to debate whether with the $8000.00 which we are now paying him we can afford to go out and employ an Assistant Secretary as well.

Your Councilor did not vote for the employment of such an Assistant Secretary, but his mind is still open to conviction.

Probably it would serve every purpose best if you would individually give me your ideas along this line. May I have a line from some or all of you?

With best personal wishes to you all and my condolences to the MOOSE, I am

Very sincerely yours,

SPENCER D. BEEBE.

EDITOR'S NOTE: The Secretary agrees, with Dr. Beebe, that the members should be fully informed and he is therefore appending certain data which has appeared from time to time in the Journal.
1. Only those expenditures made from the dues of the members are included in the budget of the Society. The Secretary receives $6,800 from that source; $1,200 from the Journal which, although doubled in size, has been self-sustaining for three years as compared to an average annual cost to the Society of $5,500 prior to 1923. By reason of this saving the net cost to the Society of the salary of the Secretary is $1,300.
2. The *entire* salary of the Secretary is printed in the Journal. See pp. 514–516, Vol. 23; p. 114, Vol. 26; pp. 90–91, Vol. 27; pp. 87–88, Vol. 28; was given orally before 47 county societies in 1930; will be printed in Journal for February, 1931.
3. Every member is entitled to know all details of the finances of the Society. See February, 1931, Journal for Council action on 1931 budget.

Alcoholism claimed 113 Wisconsin lives in 1929 to mark the highest death rate from this cause in the history of the state, according to the bureau of vital statistics, state board of health.

In 1920, records of the bureau show, the death rate from alcoholism in the state was less than one per 100,000 population. Last year this rate rose to 3.8 deaths per 100,000 population, and in only one of the intervening years has the annual rate shown a decrease from that of the preceding year.

Of the 113 deaths from this cause last year, 108 victims were males and 5 were females. The age group 40 to 49 years suffered most heavily from alcoholism, and further tabulation shows that 60 of the deaths occurred in urban and 53 deaths in rural districts of the state.

* * *

Records being kept for the first time by the juvenile department of the state board of control under the children's code show that 1,218 illegitimate babies were born in the state since September 1, 1929, when the code went into effect. It is admitted that the figures are incomplete as the code requires only hospitals to report cases of unmarried mothers. Doctors are not required to report cases outside hospitals although some of these cases are reported voluntarily. Most of the illegitimate births involve girls under 18 years of age.

* * *

Licenses have been issued this year to 138 maternity institutions in Wisconsin, including hospitals and homes, it has been announced by the state board of health. The aggregate facilities include approximately 2,700 beds.

* * *

A total of 215 Wisconsin men over the age of 60 years were the grooms in marriage licenses granted in the state in 1929, according to the bureau of vital statistics, state board of health, while brides of this age group numbered but 100 during the period.

* * *

No wild game can be kept in cold storage in Wisconsin after Dec. 31, the state conservation commis-

sion warns. Federal laws regulating the possession of any migratory birds, ducks, geese, etc., prohibit keeping these birds in storage after Dec. 31. The permits issued by the conservation commission for the possession of pheasants, ducks, or other game legally killed in other states by Wisconsin hunters, also expire on the same day. There is a special provision for keeping deer.

* * *

A total of over 7,000 sheep, 13 goats, 232 cattle, 450 hogs, and over 8,000 ducks, geese, chickens, and turkeys were killed by dogs in this state during the years 1928–1929, according to O. J. Thompson, secretary of the department of agriculture and markets. Total indemnities paid to farmers and others by counties for the same period were over $80,000.

A human fondness for dogs keeps many persons from realizing the damage done by their family pets, Mr. Thompson says. Damages done by dogs, however, resulted in the passing of the state dog-license law ten years ago, whereby every dog owner is required to pay a license fee of one dollar for male dogs and two dollars for females.

* * *

An early adjournment of the legislature, probably in May, is forecast by some legislators. Assemblyman C. A. Beggs, Rice Lake, sees the coming session of the legislature shortened at least a month because of the operation of the new budget law. The plan of Governor-Elect Philip F. La Follette to draft bills on major progressive pledges before the legislature meets is also expected to be a short-session factor.

* * *

Plans for reapportionment of legislative districts to conform with the shift in population as shown in the 1930 census brings out the fact that Wisconsin is on its way to become an industrial rather than an agricultural state. Many of the rural sections have lost population and this is true largely of the non-industrial north and western part of the state. The industrial south-eastern part of the state has shown big gains.

The senate has, for years, held a majority of city representatives and if the population shift were followed closely in a new districting plan the assembly would also go into the control of city members. Milwaukee alone plans on demanding 25 assemblymen, one-fourth of the entire membership of the lower house.

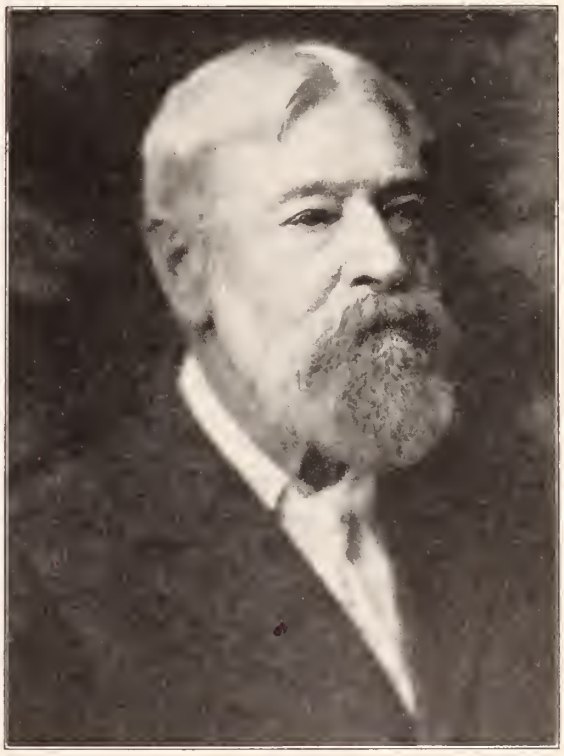
Inauguration Honors Doctor Philip Fox

While Dr. Philip Fox, veteran Madison physician, spent a lifetime in the healing art away from politics, he has seen his name carried on into the governor's chair. Philip Fox La Follette is the first Wisconsin governor to carry a physician's name.

Dr. Fox, who first practiced as a surgeon in the Civil War, was the family physician of the La Follette family through the years when the late Senator Robert M. La Follette fought and won his place in political history. On May 8, 1897, in the course of many other services for the La Follette family, Dr. Fox went to the La Follette home, then at the corner of Broom and Wilson Streets, Madison, and ushered the newest La Follette baby into the world.

To La Follettes, Philip Fox stood, and still stands, as the designation of an inspirational character and the young son was given whatever advantage another's name might hold.

Dr. Fox will be 91 on March 27. If he were younger he could not have escaped being one of the central figures at the inauguration ceremonies in the capitol on January 5. But the weight of years saw him honorary chairman at the inauguration ceremonies when Philip Fox La Follette was officially made governor of Wisconsin.



Dr. Philip Fox of Madison for whom Governor LaFollette was named.

Throughout the arduous political battle of the late senator there was an unobtrusive back-ground figure who was highly appreciated within the family circle although those outside seldom considered the family "lifeguard" as part of the general battle.

When Bob La Follette was governor of the state he found a rest necessary and made his way to a western ranch. But a western ranch would have been a long way from the family physician so Dr. Fox was prevailed to go with him.

Dr. Fox has been seeing Bob and Phil La Follette since their days of childhood ailments. He will continue to see them as senator and governor. Hardly a month passes that he does not see both of them and the first duty of a La Follette after a trip is always a visit with the veteran adjuster of human machinery.

Dr. Fox was born on March 27, 1840, at Lexington, Indiana, was educated at Sinsinawa Mound, and received his medical degree from Bellview Hospital Medical School, New York City, in 1863.

Immediately upon graduation, Dr. Fox entered the army as Assistant Surgeon to the Second Wisconsin Volunteers, and he held that position for approximately one year. He had his first service in the Wilderness Campaign and from then on was active.

At the close of the war he returned to Madison and entered into the practice of Medicine with his uncle, Dr. William H. Fox of Oregon. He practiced with his uncle from 1865 to 1872. In 1872 he moved to Janesville, and practiced there from 1872 to 1877. On January 1, 1877, he returned to Madison where he continued his practice of medicine until about 1917, when he retired.

Assemblyman Proposes Bill to Permit Deduction of Costs of Illness Under Wisconsin Income Tax Law

As a partial solution to the problem of the distribution of the costs of illness, Assemblyman Harold M. Groves of Madison, will introduce a bill into the legislature in January to provide that the costs of illness during the year shall be a deductible item from income under the state income tax law. Mr. Groves, professor of economics at the University of Wisconsin, has prepared the following statement for this Journal on this proposal.

"The purpose of the personal exemption and the exemption for dependents in our state income tax law is to make the law more closely accord with ability to pay. Five thousand dollars to a man with a wife and five dependent children is not the same thing as five thousand dollars to a bachelor. It is also true, of course, that five thousand dollars to a man with a sick wife and heavy medical expenses is not the same as five thousand received by a man whose wife is in good health. But the income tax law has never carried logic to the point of differentiating in the tax required from the latter two taxpayers.

"There can be no doubt that taxpayers resent the injustice of the present situation, with medical expenses non-deductible. Take as an exhibit the following letter which we recently received:

"'A write-up in to-nite's Journal gives me an opportunity to express my opinion on your Income Tax Plan. Here is an actual experience that will answer that quickly. I have had sickness in our home for 13 months with constant care of different surgeons and specialists. The patient (my mother) was in the hospital three times and she passed away after all our efforts and pains we used trying to save her. Now here is a problem: yearly wages of about $1500.00 to $1600.00; doctor, hospital, nurse, and housekeeper, $400.00 per month. This is without the ordinary household expenses. Sickness in house for one year approximately $4500.00. Now this is an incidental loss, but still a wage earner is not exempt of this loss on his income tax, but take a wealthy person losing just a few mills on a dollar in stocks and bonds is exempt. Where is the right side of the law.'

"Another aspect of the deduction of doctor bills is that it would give additional information to assessors as to the income of physicians and would thus tend to strengthen the administration of the tax law.

"The provision for the deduction of medical expenses from income under the state income tax will be presented to the next Wisconsin legislature."

Anti-Vivisectionists Circularize Legislators Urging Bill to Exempt Dogs; Society Attacks Medical Profession

The Wisconsin Anti-Vivisection Society, organized a year ago by the parent society, will use their best efforts to secure legislation to exempt dogs from any form of vivisection except such operations as may be essential to relieve their suffering. Claiming that the medical profession can show no results from vivisection and that vaccines are not only worthless but harmful, the Wisconsin Society will make a general attack upon the methods used by the medical profession of the state.

Petitions urging passage of the bill have been sent over the state so that each member of the legislature may receive one every day during the entire legislative session. In addition a book "Horrors of Vaccination" has been generally distributed. Just before the first of the year, each legislator received a pamphlet on the aims of the Society. A Milwaukee chiropractor is president of the Wisconsin branch.

"DOG BILL" A WEDGE

That the aim of the organization is to prohibit vivisection on all animals and that the present bill to affect only dogs is but a means of attempting to secure a wedge, is admitted by the organization. They state that the public is not as yet ready to support a total abolition bill but believe that many organizations will support the bill for dogs.

The scope of the efforts of the organization is well indicated in a letter from its Secretary to physicians residing in the city of Delavan which was accompanied by a questionnaire. Both follow:

WOMAN WRITES PHYSICIANS

(From Mrs. Winifred Wilkins, Secretary of the Wisconsin Anti-Vivisection Society, Delavan, Wis.)

An effort to determine whether a majority of practicing physicians of Delavan, Wis., favor experimentation upon live animals and the application of the results upon human beings, is being made by The Wisconsin Anti-Vivisection Society.

A list of questions is being submitted to the medical doctors in Delavan by the Society, according to Mrs. Winifred Wilkins, Secretary, and answers will be made public.

We are convinced, says Mrs. Wilkins, that many thousands of physicians do not use vivisectional medicines (vaccines and serums) and that many more deplore the department of medical research, known as vivisection, and regret that vivisection, with all its horrors and mistakes has become such an integral part of the medical argumentarium —they say this freely in private, but only a few of them dare to say so in public, because they know the power of the self-imposed leaders of the profession, and know that bigotry, intolerance and persecution are the watch words of the class of men who make loud claims that they are working for "the good of humanity." So the average physician has been forced to defend the practice or risk the ire of the American Medical Association—the most tyrannical organization existing. Now however a new freedom is coming, we are sure to the medical men, and we feel confident the statistics we will obtain as a result of this questionnaire will present a startling picture.

OPEN LETTER DELAVAN PHYSICIAN

Dear Sir:

We are desirous of obtaining data as to the stand of the medical profession in Delavan, Wis., on vivisection and serum prophylactics, and with that view we have prepared and are submitting to all medical men in this city the enclosed questionnaire.

As you are aware, thousands of allopathic physicians do not use vivisectional medicine and many more deplore that department of medical research known as vivisection.

Has it occurred to you, as a medical man—and naturally concerned in the maintenance of good practice—that the reason for the growing trend of the public away from the orthodox medical man to the so-called unethical healers of other schools—with the consequent loss and detriment to your profession—is largely due to the fact that the public is beginning to dislike and distrust and to fear the allopathic insistance on the administration of vaccines and serums, knowing as it must know, something of their genesis and reading and hearing much about the dangers and fatalities resulting from their administration? And where attempts

are made to force the use of these vaccines and serums,—this distrust is rapidly resulting into active hostility to the whole medical profession.

We have no desire to oppose the medical profession—but we are strongly opposed to those whose judgment is so unawakened and whose sympathies have become so deadened as to practice vivisection themselves or condone in silence the atrocious cruelties connected with vivisectional laboratories—cruelties that have been heartily condemned as misleading, merciless and dangerous to human welfare, by scientists, eminent doctors and thinkers, honored and respected throughout the entire world.

We condemn those who commit and almost equally those who defend and uphold these old time practices. These things we know are perpetuated by a certain type of persons, of very different order to the generally beloved and welcome doctor in ordinary medical practice—and it is to this body of doctors that we are submitting this letter, and from whom, we are certain we will receive a courteous response.

Statistics show that a large and ever increasing percentage of patients—many of them long time invalids, recover by the use of antimedical methods and we desire to obtain the list of physicians familiar with and in touch with these other later teachings, who by their replies to our questionnaire, prove themselves to be in favor with our progressive humane ideals.

We believe that when the nature of these disgusting and revolting vivisectional remedies—made from thoroughly diseased animals for the express purpose of diseasing the sick and well—becomes better understood, that the thousands of progressive medical practitioners will be the first to banish all such remedies from their medical chest, while the public will decline to accept such revolting medication.

Sincerely yours,

WINIFRED WILKINS.

QUESTIONNAIRE

1. In the interests of the great commercial serum-producing companies, to provide material for scientific curiosity, and as demonstrations before students, living and conscious animals are put to much suffering, mutilation and death in research laboratories. In your opinion, is this both justifiable and ethical?

A: _____

2. Do you approve of methods born out of vivisection?

A: _____

3. Do you believe in and make use of sera?

A: _____

4. Do you approve of the Schick test?

A: _____

5. Would you administer serum to your own child?

A: _____

6. Do all sera contain the virulent germs of the very disease they are intended to prevent and cure?

A: _____

7. Do you think past results justify the continued use of the so-called preventive sera?

A: _____

8. Do you believe in the efficacy of antitoxin?

A: _____

9. WILL YOU GUARANTEE that the use of serum antitoxin, or any other similar preventive method, or cure, will have NO HARMFUL EFFECTS?

A: _____

10. Is it not a fact that there is a wide difference of opinion among medical men as to the benefits of serum therapy?

A: _____

11. Do you believe in the efficacy of vaccination as a preventive of small pox?

A: _____

12. Will you GUARANTEE that vaccination will have NO harmful after effects?

A: _____

13. Will you GUARANTEE that vaccination will prevent small pox?

A: _____

14. In your opinion what has been the chief factor in the decline of small pox—vaccination or improved sanitations?

A: _____

WORDS OF A CATHOLIC PRIEST

(Printed in the Animal Champion, London, England)

"If God had allowed man to enrich his knowledge by the means of the torture of millions and millions of animals by the most refined means that can be devised by sadistic brains—if God, the good and loving God, who is Love itself, and hates nothing that He has made, if this God had really given permission to the doctors and professors in the interest of suffering humanity, to subject the dumb creation to all the revolting horrors of vivisection—then I should have to doubt the love and mercy of this God. No, a God who was in agreement with vivisection would not, in my eyes be a loving God. Before such a God I could only feel paralyzing fear and incurable terror. If vivisection were allowed by Christian views, I should have to turn my back on Christianity—He therefore who decidedly and uncompromisingly opposes vivisection, is doing a good work, a work pleasing to God, a work beneficial to both animals and man."

PROF. DR. JOHANN UDE,
Graz, Austria.

(Translated from the journal Freiheit dem Tiere, Munich, January, 1930.)

Meeting of Committee on Public Policy

University Club, Milwaukee
December 7, 1930

The Committee on Public Policy was called to order at the University Club, Milwaukee, at 10:00 a. m., Sunday, December 7th, by Chairman Otho Fiedler, Sheboygan. Present: Doctors Fiedler; S. M. B. Smith, Wausau; C. A. Harper, Madison; Mr. Fred M. Wylie,

Madison, and Mr. J. G. Crownhart, Secretary. Absent: Dr. Carl S. Harper, Madison.

1. The Committee discussed at length recommendations and suggestions of the Governor-elect made to the Society with reference to the appropriation section relative to law enforcement. The Secretary was instructed to write the Governor-elect as to the attitude of the committee and officers present.

2. The Committee discussed, in some detail, the general subject matter of special taxes on physicians and the Secretary was instructed as to the attitude of the Committee so that he might represent the Society on any proposal in that field during the 1931 session of the legislature.

3. The subject matter of the itinerant practice of medicine was discussed. In view of defeat in the 1929 session of the legislature and of the importance of other legislation for the 1931 session, it was voted not to re-introduce this repeal bill this year.

4. The Secretary read a letter from a member referring to sanitary conditions at drug store lunch counters. The matter was referred to the State Health Officer.

5. A telegram was read from the American Medical Association with reference to extension of the Sheppard-Towner Act. It was the concensus of opinion that no action should be taken at this time.

The Committee resolved itself into a joint session with the Committee on Public Policy of the Medical Society of Milwaukee County. Present: Doctors Gilbert Seaman, Chairman, Dexter Witte, E. L. Tharinger, R. L. Sproule and Mr. Theodore Wiprud, executive secretary. Absent: Dr. A. W. Gray.

6. The Secretary was instructed to see the Attorney General of the State to ascertain whether or not some one deputy attorney general could not be assigned to writing all oplnions referring to public health so as to have one deputy who was thoroughly familiar with all questions arising in the field.

7. It was voted by the Committee that Col. Gilbert E. Seaman and Dr. Otho Fiedler should constitute a contact committee for the health committee of the American Legion—this in accordance with authorization of the September Council meeting.

8. The subject of fees for examining those alleged to be insane was discussed at length. It was the concensus of opinion that the Society as such should make no recommendations on the subject at this session.

9. The Committee approved the action of the House authorizing the introduction of a bill to the effect that if in the opinion of the county judge, equal service at a lesser cost to the county could be had for indigent cases, the county judge might order home treatment instead of sending such cases to the State of Wisconsin General Hospital.

At this point the joint committee resolved itself into session with representatives of the legislative committee of the State Board of Medical Examiners, including Dr. R. L. Murphy, President of the Board, Eau Clalre; Dr. R. E. Flynn, Secretary of the Board, La Crosse; Dr. Roy Rodecker, chairman of the legislative committee, Mercer; Dr. John L. Guy, Milwaukee, and Dr. J. Gurney Taylor, Milwaukee. Absent: Dr. T. J. Sheehy, Tomah.

10. (a) The Board urged the continuation of the appropriation for the investigator.

(b) Secretary Flynn presented the following recommendations for bettering the medical practice act at such time as changes in the law might be appropos:

1. A better definition of what constitutes the practice of medicine.

2. Lodge more discretionary power to the Board with reference to what should constitute the preliminary and professional education of all applicants.

3. Lodge more discretionary power with the Board as to what constitutes a "reputable college".

4. Repeal the list of subjects for the examinations.

5. Urged that formal recognition be given for reciprocity with the National Board of Medical Examiners.

6. Urged repeal of the reciprocity fee of $15 under the basic science law for those practitioners who were licensed in other states prior to the passage of the Wisconsin law in 1925.

7. Exempt the older practitioners from the one year internship requirement for licensure in Wisconsin.

8. Provide a better definition of the law of what constitutes "consultation practice" which may be done without license in Wisconsin.

9. Give the Board the power to revoke licenses.

10. Dr. Flynn urged annual re-registration of physicians with annual fees in event that the legislature failed to continue the present appropriation for the investigator.

(c) Dr. Rodecker urged legislation to provide for temporary permits.

(d) Dr. Taylor urged that when licenses were revoked that the actual license be secured and returned to the State Board of Medical Examiners.

(e) To clear up any question, Dr. Taylor urged that where the law provides for a dimploma as a prerequisite to take the examination, the words be changed to provide for a "medical diploma granting an M. D., or D. O., degree."

(f) Members of the Board asked for power to adopt rules and regulations which would have the effect of law.

11. The joint committee discussed in some detail the question as to continuing the present composition of the Board. The State Board of Medical Examiners was asked to give their recommendations to the State Society committee following the meeting of the State Board on January 13th.

The joint session then dissolved and the State Society committee continued.

12. The Committee urged the Secretary to take all necessary steps to preserve the present basic science law and other laws governing other branches of treating the sick.

13. The Committee approved the introduction of bills to provide for representation of the medical profession on the county and city public health committees as authorized by the last session of the House of Delegates.

14. The Committee voted that the Society should make no recommendations and take no part in such questions presented to the legislature as were essentially questions of public policy in which the part of the profession was but a minor one.

15. The Committee discussed the question of poor relief.

16. The Committee authorized the Secretary to appear in opposition to the proposed bill on the subject of anti-vivisection. Adjournment was taken at five p. m.

J. G. CROWNHART,
Secretary.

Approved:
OTHO FIEDLER, M. D.
Chairman.

CONSOLIDATION PROPOSED

It is understood that the legislative interim committee on Education will propose a single state board with a department of registration. Such department would be the headquarters for the records of all licensing boards in the state.

Federal Income Tax Provisions Affecting the Medical Profession

This digest was approved by the Internal Revenue Collector for Wisconsin as of December, 1930. Last action of Congress included.

The Revenue Act of 1928, effective as of January 1, 1928, made no change in the rates of tax affecting individuals but did increase the maximum "earned income" allowable from $20,000 to $30,000.

Returns must be made to the Collector of Internal Revenue of the District in which the individual affected resides before March 15,1931, at which time the tax is due and payable. In event the taxpayer desires to pay the tax on the installment basis, the first installment of one-quarter of the tax is due on March 15, 1931, and a quarterly installment every three months thereafter, namely, June 15th, September 15th, and December 15th.

Responsibility for making these returns is vested with the individual. Blank forms are mailed to all known persons who have previously made returns. Failure to receive such forms, however, will not be accepted as an excuse for failure to file within the time specified by the law.

Under regulations effective last year, all persons deriving incomes from a business or profession, or both, are required to file their return upon Form 1040 (the large form). The small form, or 1040A, is for persons who secure their incomes from wages, salaries or interest alone and where the gross amount is less than $5,000. The large form, or 1040, is also used by persons reporting an income of $5,000 or over, regardless of the nature of its source.

The large form, or 1040, will be mailed to all Wisconsin physicians by the Collectors of Internal Revenue. If such blank is not received, apply to the Collector of Internal Revenue of the district in which you reside.

TREASURY DEPARTMENT

Internal Revenue Service
Milwaukee, Wis.

The State Medical Society of Wisconsin,
% Mr. J. G. Crownhart,
Madison, Wisconsin.

Dear Mr. Crownhart:

Reference is made to your letter together with the clippings from your Journal with special reference to the federal income tax as applied to physicians.

In reply, you are informed that I have reviewed the articles submitted and I find that the statements as made are correct.

With reference to the depreciation allowable, you are informed that the regulations do not prescribe any definite rate to be used, but each rate to be used is based upon the estimated life of the assets depreciable; for instance, if the estimated life of an automobile is four years, then the depreciation rate would be 25%. The depreciation rates, however, which you have used appear to be fair and reasonable. There are accordingly no changes to be made in your articles submitted.

The Income Tax Regulation No. 74 is still in effect, a copy of which I am forwarding you under separate cover. * * *

I am returning to you the papers submitted for review.

Respectfully
A. H. Wilkinson,
Collector.

RATES OF TAX

Normal Tax Rates for the calendar year 1930: First $4,000 in excess of credits, one and one-half of one per cent; next $4,000, three per cent; and the remainder of net income five per cent.

The Surtax Rates: Surtax is computed upon net income before personal exemption dividends and taxable liberty bond interest are deducted. The surtax is not applicable to net incomes of less than $10,000.00 and upon net incomes in excess of that amount, the tax is levied on a graduated scale. A partial list of surtax rates is shown below:

	Rate of Tax	Tax
Net incomes up to $10,000		
In excess of $10,000.00 and not in excess of $14,000.00	1%	$ 40.00
In excess of $14,000.00 and not in excess of $16,000.00	2%	80.00
In excess of $16,000.00 and not in excess of $18,000.00	3%	140.00

In excess of $18,000.00 and not in excess of $20,000.00	4%	220.00

For example, a person having a net income of $11,500.00 will be required to pay a 1% surtax on that amount of income in excess of $10,000.00 or 1% on $1,500.00, a surtax of $15.00. A person whose net income was $14,800.00 would compute his surtax at 1% on the first $4,000.00 in excess of $10,000.00 or $40.00 plus 2% on net income in excess of $14,000.00, that is, 2% on $800.00, $16.00; a total of $56.00 surtax.

LIABILITY TO FILE

If married, a return should be filed if the net income was $3,500 or over. If single, a return should be filed if the net income was $1,500 or over. If the *Gross Income* was $5,000, or over, a return is required whether married or single, and regardless of the net amount left over after legitimate expenses are deducted.

Liability to file a return is contingent upon the amount of net income, and not upon a net income with personal exemptions deducted. In other words, if the net income was $1,500 or $3,500, single or married respectively, and personal exemptions reduce these amounts, individuals *will not be required* to pay a tax, but *must file a return.*

In case the status of a taxpayer changes during the taxable year, the personal exemption shall be an amount which bears the same ratio to $1,500 as the number of months during which the taxpayer was single bears to twelve months, plus an amount which bears the same ratio to $3,500 as the number of months which the taxpayer was married and living with husband or wife, or was the head of a family, bears to twelve months. For this purpose a fractional part of a month shall be disregarded unless it amounts to more than half a month, in which case it shall be considered as a full month. The amount of personal exemption shall not exceed $3,500 where the head of a family is married during the taxable year.

DEDUCTIONS AND DEPRECIATIONS ALLOWED

A summary of deductions and depreciations which may be entered in the tax return and many of which are peculiar to physicians alone, are listed below. The number given after each heading refers to the paragraph numbering on the pages following which explain, in detail, how to arrive at the deductions and the depreciations.

DEPRECIATIONS ALLOWED

Automobile—Professional use (3)
- 25% cost price
- Classification includes snowmobiles.

Instruments (5)
- 20% of purchase price surgical instruments

Library (7)
- 10% on medical books

Office (6)
- 10% cost furnishings and fixtures

DEDUCTIONS

Automobile—Professional use (3)
- Cost of upkeep
- Cost of repair
- Salary of chauffeur

Debts (12)

Dues—Professional (9)

Any paid in interest of business or profession
- County Society
- State Society—$10
- Special Societies
  - College of Surgeons
  - College of Physicians, etc.

Fire—Losses by (11)

Insurance premiums (11)
- State Medical Defense, $2
- Other malpractice policies

Auto—Public liability
- Auto theft
- Auto fire
- Theft of professional equipment

Fire—Professional equipment

Lawsuits (11)
- Expense in defending malpractice suit

Library (7)
- Subscriptions to medical journals—scientific publications

Medical meetings (10)

Medicines—Suppiles (5-11)
- Medicine used in office

Bandages
- Laboratory materials

Other supplies necessary to operate office
Office (6)
Cost of telephones
Cost of heat
Cost of light
Cost of water
Taxi fare, car fare, railroad fare on professional calls
Office Rental (2)
Personal Exemptions (1)
Salaries (4)
Nurse
Laboratory assistant
Stenographer
Clerical worker
Maids, caring for office and phone
Any other employee rendering service in connection with practice or care and treatment of patients
Scientific Meetings (10)
Spectacles—Sale of (11)
Taxes—Licenses (8)
Upon any materials required in professional work
Licenses to prescribe or use alcohol
U. S. narcotic tax
U. S. Dues Tax on Club Dues
Auto license
Re-registration fees if any
Occupational tax if any
Traveling Expenses (10)

1. PERSONAL EXEMPTIONS ALLOWED

If married and living with wife, or the head of a family for the entire year an exemption of $3,500 is permitted.

If single, and not the head of a family, the personal exemption is $1,500. And additional $400 for each person, other than husband or wife, dependent upon and receiving support from you, is allowed, provided the dependent is under 18 years of age, or incapable of support because of mental or physical condition.

In the case of a change in marital status during the year, the exemptions of $3,500 and $1,500 shall be prorated over the period of married and single state.

2. OFFICE RENTALS

If a physician pays rent to another person for office space, he is permitted to deduct the amount from his gross income. This includes regular office space in a rented home provided office hours are maintained. If he owns his home and maintains an office in it, he cannot claim a deduction for office rent.

3. AUTOMOBILE

The cost of repair and upkeep of an automobile used in professional visits may be deducted. A "snowmobile" used by physicians in making winter rural calls is classed as an automobile and its depreciation and expense deductions are permissible. The salary of a chauffeur, if most of his time is spent in driving to professional calls, may also be deducted. Sums spent for taxi hire, car fares, etc., while on professional calls, may be deducted. The cost of a business automobile may be depreciated.

If the total cost of an automobile is $2,000 and its estimated period of usefulness is five years, $400 or 20 per cent of the cost may be deducted each year for 5 years.

4. ASSISTANTS

Deductions are permitted for the salary of a nurse, laboratory assistant, stenographer or clerical worker in the office so long as the duties of these are in connection with the physician's professional work. Wages paid to maids taking care of the office, answering the telephones are also deductible, as are any funds paid to employees for services rendered in connection with practice, or care and treatment of patients.

5. MEDICINES, INSTRUMENTS, SUPPLIES

Medicines used in the office to treat patients, bandaging, laboratory materials and all other supplies necessary to operate a physician's office may be deducted. Upon surgical instruments, one fifth of the purchase price may be deducted annually for five years under depreciation account.

6. GENERAL OFFICE EXPENSE

Cost of all telephones used in the office is exempt and may be deducted. Expenditures for heat, light, and water for the office may be deducted. An annual depreciation of 10 per cent of the cost of office furnishings and fixtures may be deducted.

7. LIBRARY

Most physicians have a more or less extensive library. Courts have held that medical books, during the course of ten years, become out of date. For this reason, a 10 per cent depreciation may be deducted annually.

8. TAXES, LICENSES

Any taxes paid upon materials required in professional work are exempt. All licenses, which the physician is required to take out, may be taken off the gross income reported. This includes the license to prescribe or use alcohol, narcotic tax, automobile license, local occupational taxes, etc.

9. PROFESSIONAL DUES

Dues paid to professional associations to which, in the interest of his business or profession he belongs, are exempt and may be deducted. Also subscriptions to all medical journals or scientific publications are exempt.

10. TRAVELING EXPENSES

Traveling expenses necessary for professional visits to patients are deductible. Traveling expenses in bona fide attendance upon scientific meetings are deductible (Jack vs. Commissioner of Internal Revenue—Board of Tax Appeals, Oct., 1928). Expenses in attending post-graduate medical courses are not deductible.

11. MISCELLANEOUS

Laboratory Expenses—The deductibility of the expenses of establishing and maintaining laboratories is determined by the same principles that determine the deductibility of other corresponding professional expenses. Laboratory rental and the expenses of laboratory equipment and supplies and of laboratory assistants are deductible when, under corresponding circumstances, they would be deductible if they related to a physician's office.

Losses by Fire, etc.—Loss of and damage to a physician's equipment by fire, theft or other cause, not compensated by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent it has not been made good by repair and the cost of repair claimed as a deduction.

Insurance Premiums—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries by a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment, and damage to or loss of professional equipment by fire or otherwise. Under professional equipment is to be included any automobile belonging to the physician and used for strictly professional purposes.

Expense in Defending Malpractice Suits—Expenses incurred in the defense of a suit for malpractice are deductible as business expense. Expenses incurred in the defense of a criminal action, however, are not deductible.

Sale of Spectacles—Oculists who furnish spectacles, etc., may charge as income money received from such sales and deduct as an expense the cost of the article sold. Entries on the physician's account books should, in such cases, show charges for services separate and apart from charges for spectacles, etc.

12. WHEN TO DEDUCT DEBTS

If the physician's books are kept according to the "Cash Receipts and Disbursements" system, he may not charge off any unpaid debts because "if his books are kept according to this system, he is only reporting as gross income those accounts which have proved to be good and therefore bad accounts cannot be deducted because they have already been excluded."

If the books are kept upon an "accrual basis" (that is, if the basis of expense actually incurred and payable even though not yet paid, or income earned although not yet collected), it is permitted to charge off on the income tax blank all debts which have been definitely ascertained to be worthless, and charged off on the books or records, during the fiscal year covered by the report.

In the same way, the physician is permitted to claim deductions for all other ex-

penses within the scope of his profession, and the amount of his tax is determined on the *net income* which remains after all these items *have been deducted.*

ITEMS NOT REPORTABLE AS INCOME

Allowances received under the War Risk Insurance act; bequests; damages received in personal actions; dividends on stock of federal reserve banks, land banks and intermediate credit banks; dividends from exempted building and loan associations up to $300; dividends from corporate earnings accumulated prior to March 1, 1913; gifts; inheritances; insurance proceeds paid by reason of death of the insured (where a policy matures during life the amount of the proceeds, in excess of the net premiums paid, is taxable income); state court jury fees; state court receivership fees, life insurance proceeds; and stock dividends.

All interest received from obligations of a state or political sub-division thereof; from securities issued under the Farm Loan act; interest on Liberty 3½% Bonds and U. S. Bonds issued prior to September 1, 1917, and interest on the obligations of the possessions of the U. S. need not be included in the computation of gross income.

Interest received on Liberty 4% and 4¼% bonds and Treasury 3⅜%, 3¾%, 4% and 4¼% bonds are exempt up to $5,000 aggregate principal. All interest received on such obligations in excess of $5,000 total holdings is reportable for surtax purposes. All interest received on U. S. Treasury notes (as distinguished from Treasury bonds), must be reported. However, all interest received from obligations of the United States, which is reportable as income, is subject only to the surtax.

EARNED INCOME

For several years students of income taxation have contended that income derived from the personal endeavor of a tax payer should not be taxed at as great a rate as is income derived from other sources. This fact is now recognized in the law which provides that the income shall be first computed in the usual way and then it shall be recomputed on the earned income as if that income were the entire income.

The term "Earned Income" means wages, salaries, professional fees, or compensation for services.

The first $5,000.00 of net income is considered earned income, no matter from what source derived. The 20% limitation placed on net income derived from a business where both capital and personal service are material income producing factors, is not applicable to physicians whose income is held to be directly attributable to their rendition of personal service. However, in no case may the earned income be considered to be more than $30,000.00.

It is anticipated that the earned income credit provision of the law will create a great amount of confusion in the computation of tax and for the benefit of our readers an example applicable to the income of a physician is given below:

Net in come from practice	$ 8,000.00
Net income from rents	500.00
Net income from sale of property	5,000.00
Total net income	$13,500.00

Taxpayer married with two dependents under 18 years of age.

COMPUTATION

Net income	$13,500.00
Marital exemption $3,500; dependent exemption $800	4,300.00
Subject to normal tax	9,200.00
First $4,000.00 subject to normal 1½% tax	4,000.00
	5,200.00
Second $4,000 subject to normal 3% tax	4,000.00
Remainder subject to normal 5% tax	1,200.00
Normal 1½% tax	60.00
Normal 3% tax	120.00
Normal 5% tax	260.00
Surtax 1% on net income in excess of $10,000.00	35.00
	275.00
Earned income credit (see computation below)	13.88
Total tax due	261.12

COMPUTATION OF EARNED INCOME CREDIT

Earned income (income from practice)	8,000.00
Exemption	4,300.00
Subject to normal tax	3,700.00
Normal 1½% tax	55.50
Earned income credit ¼ of tax on earned income or	13.88

State Income Tax Laws

This digest was approved by the Wisconsin Tax Commission, December, 1930.

DEDUCTIONS FROM INCOMES OF PERSONS OTHER THAN CORPORATIONS

71.04 Persons other than corporations, in reporting incomes for purposes of taxation shall be allowed the following deductions:

(1) Payments made within the year for wages or other compensation for services actually rendered in carrying on the profession, occupation or business from which the income is derived. But no deduction shall be made for any amount paid for services actually rendered in the carrying on of the profession, occupation or business from which the income is derived unless there be reported the name and address and amount paid each person to whom a sum of seven hundred dollars or more shall have been paid for services during the assessment year. No deduction shall be allowed under this section for any amounts expended for personal, living or family expenses.

(2) The ordinary and necessary expenses actually paid within the year in carrying on the profession, occupation or business from which the income is derived, including a reasonable allowance for depreciation by use, wear and tear of the property from which the income is derived, and in the case of mines and quarries an allowance for depletion of ores and other natural deposits on the basis of their actual original cost in cash or the equivalent of cash.

(3) Losses actually sustained within the year and not compensated by insurance or otherwise, provided that no loss resulting from the operation of business conducted without the state, or the ownership of property located without the state, may be allowed as a deduction, and provided further that no loss may be allowed on the sale of property purchased and held for pleasure or recreation and which was not acquired and used for profit, but this proviso shall not be construed to exclude losses due to theft or to the destruction of the property by fire, flood or other casualty. No deduction shall be allowed under this paragraph for any loss claimed to have been sustained in any sale or other disposition of shares of stock or securities where it appears that within thirty days before or after the date of such sale or other disposition the taxpayer has acquired (otherwise than by bequest or inheritance) or has entered a contract or option to acquire substantially identical property and the property so acquired is held by the taxpayer for any period after such sale or other disposition.

(4) Dividends, except those provided in section 71.02 (2) (b) 2 and 3, received from any corporation conforming to all of the requirements of this subsection. Such corporation must have filed income tax returns as required by law and the income of such corporation must be subject to the income tax law of this state. The principal business of the corporation must be attributable to Wisconsin and for the purpose of this subsection any corporation shall be considered as having its principal business attributable to Wisconsin if fifty per cent or more of the entire net income or loss of such corporation after adjustment for tax purposes (for the year preceding the payment of such dividends) was used in computing the average taxable income provided by chapter 71, except that deductibility of dividends received in the year 1926 shall be governed by the assessment of the income of the year 1925. If the net incomes of several affiliated corporations have been combined for the purpose of determining the amount of income subject to taxation under the statute, the location of the principal business of such group shall determine the taxable status of dividends paid, but inter-company dividends passing between affiliated corporations whose incomes are included in the taxable income of the group, shall not be assessed as group income.

(5) Interest paid within the year on existing indebtedness; provided, the debtor reports the amount so paid, the form of the indebtedness, together with the name and address of the creditor. But no interest shall

be allowed as a deduction if paid on an indebtedness created for the purchase, maintenance or improvement of property, or for the conduct of a business, unless the income from such property or business would be taxable under this chapter.

(6) Taxes other than inheritance and special improvement taxes upon the property or business from which the income hereby taxed is derived paid by such persons during the year, including therein taxes imposed by the state of Wisconsin or the United States government as income taxes; provided that such portion of the deduction for federal income taxes as may be allowable shall be confined to cash payments made within the year covered by the income tax return and provided further that income taxes imposed by the state of Wisconsin shall accrue for the purposes of this subsection only in the year in which such taxes are assessed.

(7) Contributions or gifts made within the year to the state or any political subdivision thereof for exclusively public purposes, or to any corporation, community chest fund, foundation, or association operating within this state, organized and operated exclusively for religious, charitable, scientific, or educational purposes, or for the prevention of cruelty to children or animals, no part of the net income of which inures to the benefit of any private stockholder or individual, to an amount not in excess of ten per centum of the taxpayer's taxable income as computed without the benefit of this subsection.

GENERAL EXEMPTIONS

71.05 (1) There shall be exempt from taxation under this chapter income as follows, to-wit:

(a) Pensions from the United States.

(b) All inheritances, devises, bequests and gifts received during the year.

(c) All insurance received by any person or persons in payment of a death claim by any insurance company, fraternal benefit society, or other insurer, except insurance paid to a corporation or partnership upon the policies on the lives of its officers, partners or employes.

(d) Income of mutual savings banks, mutual loan corporations, building and loan associations, and corporations or associations organized under sections 185.01 to 185.22, and of all religious, scientific, educational, benevolent or other corporations or associations of individuals not organized or conducted for pecuniary profit.

(e) Incomes derived from property and privileges by persons now required by law to pay taxes or license fees directly into the treasury of the state in lieu of taxes, and such persons shall continue to pay taxes and license fees as heretofore.

(f) Income received by the United States, the state and all counties, cities, villages, school districts or other political units of the state.

(2) There will be deducted from the tax, after the same shall have been computed according to the rates in section 71.06, a personal exemption for natural persons as follows:

(a) For an individual, eight dollars.

(b) For husband and wife or head of a family, seventeen dollars and fifty cents. For the purposes of this chapter, the term "head of a family" means a natural person who maintained a household and supported therein himself and one or more persons who were dependent upon him for support; but no additional exemption shall be allowed for those dependent upon the head of a family except in case of a widow or widower supporting children under the age of eighteen years.

(c) For each child under the age of eighteen years who is actually supported by and dependent upon the taxpayer for his support, an additional three dollars.

(d) For each additional person who is actually supported by and entirely dependent upon the taxpayer for his support, an additional three dollars, except in case of a head of a family. In computing taxes and the amount of taxes payable by persons residing together as members of a family, the income of the wife and the income of each child under eighteen years of age shall be added to that of the husband or father, or if he be not living, to that of the head of the family and assessed to him except as hereinafter provided. The taxes levied shall be payable by such husband or head of the family but if

not paid by him may be enforced against any person whose income is included within the tax computation.

(e) The personal exemptions provided by this section shall be determined by the personal status of a taxpayer on the last day of the last year included in the computation of average income except as otherwise provided in this chapter.

NEW TAX DATES

71.10 Computation of taxes and preparation of assessment and tax rolls, office audits, certification of taxes and refunds. (1) (a) The tax commission or the assessor of incomes shall determine the taxable income by averaging the net income or loss reported by the taxpayer on his current return with the net incomes or losses for the two previous years, except that the taxable income assessed in the year 1928 shall be the average of the net incomes or losses for the years 1926 and 1927 or for the corresponding two fiscal years, giving the net income or loss of 1926 two-thirds weight and the net income or loss of 1927 one-third weight.

71.10 (4) All income taxes shall become due and payable as follows:

(a) Initial assessments of taxes on incomes of persons who report on a calendar year basis shall become due and payable on June first.

(b) Initial assessments of taxes on incomes of persons who file on a fiscal year basis shall be due and payable on the first day of the sixth month after the close of the fiscal year of such person.

(c) Back assessments of income taxes omitted from initial rolls and additional income taxes assessed under sections 71.10 and 71.11 shall become due and payable on entry upon the assessment roll and certification of the tax roll.

(d) Income taxes shall become delinquent if not paid within thirty days after the same are due as provided in this chapter and when delinquent shall be subject to a penalty of two per cent on the amount of the tax and interest at the rate of one per cent per month until paid, and the county treasurer shall immediately proceed to collect the same in the manner provided in sections 74.29 and 74.30, and the county shall retain all such delinquent penalties and interest for such collections.

METHODS OF ASSESSMENT AND TAXATION RATES

(a) *Corporations.*

The incomes of all corporations are assessed by the Wisconsin Tax Commission and taxes are computed on average taxable income as defined in the statutes at the following rates:

(1) Normal Taxes

Income	Rate
Up to $1,000	2 %
Between $1,000 and $2,000	2½%
Between $2,000 and $3,000	3 %
Between $3,000 and $4,000	3½%
Between $4,000 and $5,000	4 %
Between $5,000 and $6,000	5 %
Over $6,000	6 %

(2) Surtaxes

The teachers' retirement fund surtax rate is one-sixth of the normal tax rate for incomes in excess of three thousand dollars. The surtax is computed only on incomes in excess of $3,000.

(b) *Partnerships.*

Individuals carrying on business in partnerships are liable for income tax only in their individual capacity. The partnership must file a return, however, and the net income disclosed on such return is assessable to the individual members whether distributed or not.

(c) *Individuals.*

The incomes of individuals are assessed by the assessors of incomes of the various counties and taxes are computed on average taxable income at the following rates:

(1) Normal Taxes

Income	Rate
Up to $1,000	1 %
Between $ 1,000 and $ 2,000	1¼%
Between $ 2,000 and $ 3,000	1½%
Between $ 3,000 and $ 4,000	1¾%
Between $ 4,000 and $ 5,000	2 %
Between $ 5,000 and $ 6,000	2½%
Between $ 6,000 and $ 7,000	3 %

Between $ 7,000 and $ 8,000 _____3½%
Between $ 8,000 and $ 9,000 _____4 %
Between $ 9,000 and $10,000 _____4½%
Between $10,000 and $11,000 _____5 %
Between $11,000 and $12,000 _____5½%
Over $12,000 _____6 %

(2) Surtaxes

The teachers' retirement fund surtax rate is one-sixth of the normal tax rate for incomes in excess of three thousand dollars. The surtax is computed only on income in excess of $3,000.

DEDUCTIONS AND DEPRECIATIONS ALLOWED PHYSICIANS

A summary of deductions and depreciations actually paid or incurred which may be entered in the tax return, and many of which are peculiar to physicians alone, are listed below. The number given after each heading refers to the paragraph numbering on the pages following which explain in detail how to arrive at the deductions and the depreciations.

Depreciations Allowed

Instruments (d)
Library (f)
Office (e)

Deductions

Automobile—Professional use (b)
  Cost of repair
  Cost of upkeep
  Salary of chauffeur
Debts (i)
Dues—Professional (h)
  Any paid in interest of business or profession
    County Society
    State Society
    Special Societies
    College of Surgeons
    College of Physicians, etc.
Fire—Losses by (k)
Instruments, life—less than one year (d)
Insurance premiums (j)
  State Medical Defense
  Other malpractice policies
  Auto—Public liability
  Auto theft
  Auto fire
  Theft of professional equipment
  Fire—Professional equipment
Lawsuits (l)
  Expense in defended malpractice suit
Medicines—Supplies (d)
  Medicine used in office
  Bandages
  Laboratory materials
Other supplies necessary to operate office
Office (e)
  Cost of telephone
  Cost of heat
  Cost of light
  Cost of water
  Taxi fare, car fare, railroad fare on professional calls
Office Rental (a)
Personal Exemptions
Salaries (c)
  Nurse
  Laboratory assistant
  Stenographer
  Clerical worker
  Maids, caring for office and phone
  Any other employee rendering service in connection with practice or care and treatment of patients
Spectacles—Sale of (m)
Taxes—Licenses (g)
  Upon any materials required in professional work
  License to prescribe or use alcohol
  U. S. Narcotic tax
  Auto license
  Re-registration fees, if any
  Occupational tax, if any
  Real property tax on office
  Personal property tax on apparatus and equipment
  Income taxes paid
  Deductions (Expenses Incident to the Production of Income)

(a) *Office Rentals.*

If a physician pays rent to another person for office space, he may deduct all such amounts paid from gross income in determining net income for assessment. If he rents a home and uses a part thereof as his office, he may deduct a fair proportion of total rent paid as a business expense. If he owns a home and uses a part thereof as his office, no deduction for rent may be made.

He may, however, deduct a fair proportion of depreciation, repairs, and taxes on his home as a business expense.

(b) *Automobile Expenses.*

Any physician may deduct from his gross income the cost of maintaing an automobile (also snowmobile) used exclusively for professional duties, as well as taxi hire and car fares while on professional calls. He may not deduct, however, the original cost of the automobile but may deduct instead depreciation actually sustained. A fair rate is acceptable and the circumstances of individual cases will govern. War tax paid on the original purchase of an automobile is not deductible, but constitutes part of the basic cost subject to depreciation.

If an automobile is used both for personal and professional purposes, the deductions outlined in the preceding paragraph are limited to those expenses directly attributable to its professional use. In this case a fair percentage of the total automobile expenses incurred during the year may be deducted as representing the cost of maintaining the automobile for professional purposes.

If a chauffeur is employed to drive the physician's car his salary may be considered as part of the expense of maintaining the automobile and is deductible subject to the rules laid down in the two preceding paragraphs.

(c) *Salaries of Assistants.*

Salaries paid to nurses, laboratory assistants, stenographers and clerical help may be deducted by the physician as long as their duties are entirely within the scope of the physician's professional capacity. If a maid is employed both to take care of his office and to assist in his home, however, only that portion of her salary earned in taking care of the office may be deducted.

(d) *Medicines, Instruments and Supplies.*

The cost of medicines and supplies actually used during the year may be deducted from gross income for assessment purposes. The cost of medical instruments of a life of less than one year may be deducted also as an expense.

Medical instruments with a life in excess of one year, however, may not be deducted. The cost of such instruments, constitutes a capital expenditure and should be depreciated. Depreciation actually sustained on medical instruments and computed at a fair rate may be deducted from gross income. No fixed rates of depreciation have been laid down for assets of this character and the use to which the asset is subjected will govern. In determining this rate, however, loss in value due to use, wear, and tear alone will govern, and no loss in value due to equipment becoming out of date can be considered.

(e) *General Office Expenses.*

Expenditures for telephone, heat, light and water used within the professional scope of the physician may be deducted. Likewise a fair rate of depreciation on office furnishings and fixtures may be deducted.

(f) *Library.*

A fair rate of depreciation on the physician's library may be deducted covering wear and tear sustained through use. In determining the rate, however, obsolescence may not be considered since the Wisconsin Income Tax Law does not recognize losses in value due to such causes. The fact that medical books become out of date during the course of ten years cannot be considered in determining the rate of library depreciation.

(g) *Taxes and Licenses.*

All taxes and licenses incident to the professional scope of the physician may be deducted. The following taxes would be deductible by any physician:

(1) Real property taxes paid on office owned by him and used by him in his practice.

(2) Personal property taxes paid on his apparatus and equipment.

(3) Income taxes paid.

(4) All license fees incident to his profession.

(5) Automobile licenses on automobiles used exclusively in the practice of his profession.

(h) *Professional Dues.*

Professional dues paid to professional associations to which the physician may belong in the interest of his profession may be deducted.

(i) *Losses on Bad Accounts.*

If a physician has consistently kept his books on a "Cash Receipts and Disbursements" basis and has consistently reported his income in the same manner he may not deduct unpaid debts. Under this system he reports as income only such items as have actually been collected and all unpaid fees both good and bad have already been excluded from gross income.

If a physician has kept his books and reported his income on an "Accrual Basis" (reported as income all fees for services during the year both collected and uncollected and has deducted as expense all items whether actually paid or not) he may deduct all debts definitely ascertained to be worthless in the year covered by the report.

(j) *Insurance Premiums.*

Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries by a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment, and damage to or loss of professional equipment by fire or otherwise. Under professional equipment is to be included any automobile belonging to the physician and used for strictly professional purposes.

(k) *Losses by Fire, etc.*

Loss of and damage to a physician's equipment by fire, theft or other cause, not compensated by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent it has not been made good by repair and cost of repair claimed as a deduction.

(l) *Expense in Defending Malpractice Suits.*

Expenses incurred in the defense of a suit for malpractice are deductible as business expense. Expenses incurred in the defense of a criminal action, however, are not deductible.

(m) *Sale of Spectacles.*

Oculists who furnish spectacles, etc., may charge as income money received from such sales and deduct as an expense the cost of the article sold. Entries on the physician's account books should, in such cases, show charges for service separate and apart from charges for spectacles, etc.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The American Board of Obstetrics and Gynecology, composed of nine members and examiners, elected by The American Association of Obstetricians, Gynecologists, and Abdominal Surgeons, The American Gynecological Society, and the Section on Obstetrics, Gynecology, and Abdominal Surgery of The American Medical Association, was formally organized in Niagara Falls, September 16, 1930. The function of the Board is to grant certificates indicating proficiency and specialization in Obstetrics or Gynecology, or both, to those who comply with its requirements.

The nine members of the Board are:

Dr. Walter T. Dannreuther, New York City
Dr. Fred L. Adair, Chicago
Dr. E. A. Schumann, Philadelphia
Dr. Paul Titus, Pittsburgh
Dr. Joseph L. Baer, Chicago
Dr. Jennings C. Litzenberg, Minneapolis
Dr. Robert D. Mussey, Rochester, Minn.
Dr. E. D. Plass, Iowa City, Iowa
Dr. G. D. Royston, St. Louis

This Board has been in the process of organization since 1927. It puts into action a determined effort on the part of these three national organizations to improve the standards of practice of obstetrics and gynecology. It expects to accomplish this by various activities, such as the investigation and encouragement of graduate extension study facilities and active clinical assistantships for men desiring to specialize in these branches, and it will endeavor by regular examinations to determine the competence of specialists in obstetrics and gynecology who apply for the certificate. Certain outstanding specialists will be granted certificates on the basis of their attainments alone, but only by a vote of the entire Board after recommendation by the Committee on Requirements. A second group is asked to undergo a practical clinical examination, whereas a third and younger group has both written and clinical examination and must submit records of a group of cases in order to qualify.

The national obstetrical and gynecological organizations, which have participated in the formation of the Board and are sponsoring its activities, as well as other societies, attach considerable importance to its Certificate. It is expected that both the medical and the lay public, including hospital directors, will

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PRESS SERVICE OF STATE MEDICAL SOCIETY

No serum does so much for public health as printer's ink

"NORMAL WEIGHT"

Madison, Wis., Nov. 19—Now that the season for mince pies and delicious viands of turkey and geese is approaching the State Board of Health sends out a word of caution.

Fat people are more susceptible to certain winter diseases like influenza.

Then when all the "slims" get ready to applaud, the report of Dr. C. A. Harper, director of the board, adds a word for them. Tuberculosis and pneumonia are always more fatal to the "underweights."

The only class to hear words of comfort is the "normals." Even its numbers must watch their step, declares the Educational Committee of the State Medical Society of Wisconsin, supplementing Dr. Harper's declarations.

"If we consider for a moment one phase of adult life, and that is the question of weight, the importance of this will be readily made manifest," declares the Educational Committee of the State Medical Society in a bulletin issued today. "Life insurance companies have made careful studies of this problem, largely as a matter of business sagacity. Findings have been published from time to time. It has been found that if you take the average death rate of the so-called normal weight group as 100 per cent, and compare the underweight and the overweight with the so-called normal group, a big avenue for consideration will be opened up. The overweight compared with the normal has 151 mortality from heart disease; 172 from nephritis; 165 from arterial diseases; 157 from cerebral hemorrhage; and cancer only 111 per cent. If we go a step farther, we find that overweights are especially susceptible to sclerosis of the liver the devastating influence of influenza, more subject to paralysis, endangered by angina pectoris, and even in the field of suicides the death rates of overweights are higher than the average.

"From the causes just enumerated it will be found that the underweights were very materially below the average. Heart disease approaches about 81 per cent; nephritis 77 per cent; arterial diseases 75 per cent; cerebral hemorrhage 70 per cent; and diabetes only 64 per cent. It would appear, generally speaking, that people of practically all weights are more or less equally susceptible to cancer.

"In the figures thus far presented you would form the conclusion, very likely, that the underweights had a great advantage, and in some respects they have, over those noticeably overweight. In the underweights, however, tuberculosis is over 200 per cent above tuberculosis in the normal weights, and in the markedly underweights tuberculosis is nearly 300 per cent higher. Pneumonia is more fatal with underweights, being over 110 per cent, than it is in those of normal weight.

"It will be seen therefore that the weight question presents one extremely fertile field in which the medical profession can offer most valuable advice. One of the next steps in the field of preventive medicine is to have the lay public imbued with the idea that periodic physical examinations are fundamentally essential for their own welfare and life prolongation. The medical profession should also more fully prepare itself to apply modern scientific medicine to the individual who at the time of examination may be considered as apparently healthy."

"A DOZEN MEDALS"

The State Educational Committee of the State Medical Society ought to get a dozen medals for its work the past year. Week after week, editors have gotten good advice along health lines from this committee and have passed it along to their readers. The latest word is to beware of wood alcohol, the fumes of which if taken into the lungs, produce blindness. The committee advises the passing of a law to prevent its sale for use in automobiles. The alcohol is sold under the name "Methanol" and "Methyl Alcohol." Repeated inhalations have caused death.

Editorial, Fort Atkinson Union, Dec. 5, 1930.

HIBERNATING

Madison, Wis., Nov. 26—People who desire to continue to live an active life, must not hibernate for the next six months, but they should follow simple health rules, according to the Educational Committee of the State Board of Health. The health which summer sunshine has given to the people can be preserved by the continued use of summer vegetables, by more exercise, and by plenty of fresh air.

"There is no health in hibernation," declares the Medical Bulletin issued today. "One of the most effective ways to secure and keep health and happiness is by means of an adequate and well-balanced diet. Despite the vast amount of scientific research that has gone into the development of our knowledge of nutrition, the rules for right eating are comparatively simple. Construct your daily diet around the so-called protective foods, pure milk, fruits, and especially green leafy vegetables.

"If these necessary, desirable, and comparatively inexpensive foods form the basis of the diet, indulgence of one's appetite to a reasonable degree will take care of the remainder of the body's needs. Remember that a quart of pure milk in some form ought to be consumed by every growing child every day and that adults should have at least a pint of this most nearly perfect of all foods.

"Fruits such as oranges, lemons, berries, peaches, apples, and the like, and green vegetables, such as lettuce, spinach, celery, cabbage, kale, beet greens, and turnip greens, are obtainable practically all the year. They should be and will be obtained by the wise housewife.

"Other viands, such as eggs, cereals, meats and fish help to provide a satisfactory diet for the average person, but put your faith in the protective foods. In winter, cod liver oil joins this category. It provides the vitamin D which is stimulated in the body by summer sunshine, and is rich in vitamin A, the element found so abundantly in butter and the fat of milk.

"While giving moderate and sensible attention to your diet, do not neglect reasonable exercise, preferably out in the fresh air. Don't forget that cleanli-

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THE JOURNAL BOOK SHELF

Nervous Indigestion. By Walter C. Alvarez, M. D., associate professor of medicine, University of Minnesota (The Mayo Foundation). Price $3.75. Paul B. Hoeber, Inc., New York.

Obstetrics For Nurses. By Charles B. Reed, M. D., F. A C. S., professor of obstetrics, Northwestern University Medical School; chief obstetrician Wesley Memorial Hospital, Chicago, and Charlotte L. Gregory, M. D., adjunct in obstetrics at Wesley Memorial Hospital; clinical assistant in obstetrics at Northwestern University Medical School. 144 illustrations including two color plates. Third edition. Price $3.00 C. V. Mosby Co., St. Louis.

Minor Surgery and Bandaging. By Gwynne Williams, M. S., surgeon. University College Hospital, 20th Edition, 262 illustrations. Price $3.50. F. A. Davis Company, Philadelphia.

Applied Electrocardiography. By Aaron E. Parsonnet, M. D., F. A. C. P. and Albert S. Hyman, A. B., F. A. C. P. With 102 illustrations. The Macmillan Company, 60 Fifth Ave., New York City.

Primer on Fractures. Prepared by the cooperative committee on fractures, under auspices of section on surgery, general and abdominal, and section on orthopedic surgery in cooperation with department exhibit of the American Medical Association. Price $1.00 American Medical Association, 535 N. Dearborn St. Chicago.

Practical Massage and Corrective Exercises with Applied Anatomy. By Hartvig Nissen, superintendent of hospital clinics in massage and medical gymnastics. Fifth edition, revised and enlarged by Harry Nissen, president, Posse-Nissen School of Physical Education, Boston, Mass. Illustrated with 72 original half-tone and line engravings. Price $2.50 net. F. A. Davis Company, Philadelphia.

BOOKS RECEIVED FOR REVIEW

Operative Gynecology. By Harry Sturgeon Crossen, M. D., F. A. C. S., professor of clinical gynecology, Washington University School of Medicine; gynecologist in chief to the Barnes Hospital and the Washington University dispensary. And Robert James Crossen, M. D., instructor in clinical gynecology and obstetrics, Washington University School of Medicine. 4th edition. 1246 illustrations and 2 color plates. Price $15.00. C. V. Mosby Co., St. Louis, Mo.

Treatment of Epilepsy. By Fritz B. Talbot, M. D., clinical professor of pediatrics, Harvard University Medical School; chief of Children's Medical Department, Massachusetts General Hospital. Price $4.00. Macmillan Company, 60 Fifth Ave., New York. 1930.

Intestinal Toxemia. By Anthony Bassler, M. D., F. A. C. P. Consulting gastroenterologist, St. Vincent's, Peoples' and Jewish Memorial Hospitals, New York City; St. John's Hospital, Yonkers; Christ Hospital, Jersey City. Illustrated with 16 text cuts. Price $6.00. F. A. Davis Company, Philadelphia. 1930.

Diseases of the Digestive System, Volumes I and II. By L. Winfield Kohn, M. D., F. A. C. P., formerly assistant in the gastro-intestinal Clinic, Johns Hopkins Hospital; chief of the clinic of gastro-enterology, Medico-Chirurgical College, Philadelphia; present chief of the gastro-intestinal clinic, Lebanon Hospital, New York City. Illustrated with 542 engravings, including 7 full page colored plates. Price of two volumes $12.00 net. F. A Davis Company, Philadelphia, 1930.

Microbiology and Elementary Pathology. By Charles G. Sinclair, B. S., M. D. Major, Medical Corps, U. S. Army. Instructor in bacteriology, Army Medical School. With 102 illustrations, some in colors. Price $2.50 net. F. A. Davis Company, Philadelphia, 1931.

A Compend on Bacteriology. By Robert L. Pitfield, M. D., attending physician, Germantown Hospital, Philadelphia. And Howard W. Schaffer, M. D., pathologist to the Memorial Hospital, Philadelphia; Fifth edition. 82 illustrations and 4 plates. Price $2.00 net. P. Blakiston's Son & Co. Inc., 1012 Walnut St., Philadelphia.

Physical Diagnosis. By Warren P. Elmer, B. S., M. D., associate professor of clinical medicine, Washington University. And W. D. Rose, M. D., late associate professor of medicine in the University of Arkansas. With 337 illustrations. Price $10.00. C. V. Mosby Company, St. Louis, 1930.

Chronic Arthritis and Rheumatoid Affections. By Bernard L. Wyatt, M. D., F. A. C. P., director, The Wyatt Clinic; formerly associate director, The Rockefeller Commission to France. Price $2.50. William Wood & Company, 156 Fifth Ave., New York City.

A Manual of Normal Physical Signs. By Wyndham B. Blanton, B. A., M. A., M. D., assistant professor in medicine, Medical College of Virginia. 2nd edition. Price $3.00. C. V. Mosby Co., St. Louis, 1930.

Medical Jurisprudence. A statement of the law of forensic medicine by Elmer D. Brothers, B. S., LL. B. Member of Chicago Bar; lecturer emeritus on jurisprudence in the medical and dental departments of the University of Illinois and lecturer on medical and dental jurisprudence in John Marshall Law School and on historical development of the federal constitution. 3rd edition. Price $3.50. C. V. Mosby Co., St. Louis.

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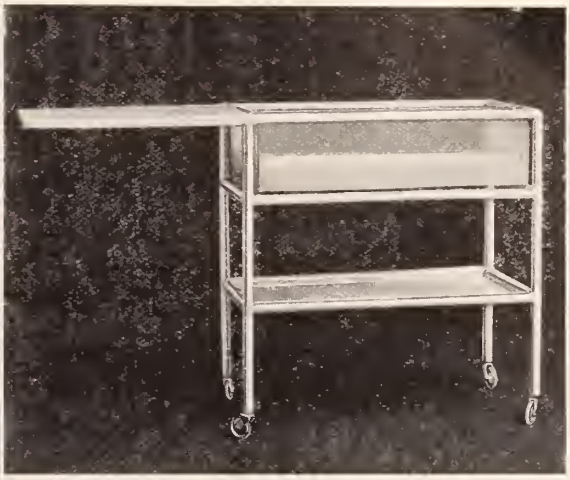

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S. H. Kilishek, engineer at Theda Clark hospital, Neenah, Wis., has invented a new piece of equipment for nurseries—The Syldores Infants Bed.

Hospital nurseries equipped with these beds will be able to combat to more advantage a form of skin disease peculiar to new born infants known as impetigo dermatitis. This disease is almost impossible to eradicate; a drop of contaminated water often infecting an entire nursery.

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May we suggest that you pull out your pad NOW and get the whole story on these beds.

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PRESS SERVICE

(Continued from page 55)

ness and the avoidance of infections, poisons, and accidents are also conducive to good health. Freedom from worry is another safeguard. Keep serene and don't excite yourself unduly about the state of your health. Just practice reasonable health habits.

"Sufficient rest and sleep and plenty of wholesome recreation round out these simple rules, the practice of which is so helpful in getting the best out of life. By the observance of these various health measures, none of which is complicated, expensive or difficult, the rigors and dangers of winter will become of minor importance."

METHYL ALCOHOL

Madison, Wis., Dec. 3—People who propose to use methyl alcohol, or nethanol, as an anti-freeze mixture for their automobiles this winter should exercise great care both in handling the mixture and in draining it into the car. Blindness has often been reported from a single small dose of methyl alcohol, according to the State Educational Committee of the State Medical Society.

"State legislature should enact laws protecting the people from the use of methyl alcohol," declares the bulletin of the Medical Society today. "In the meantime we are joining with the American Medical Association in a campaign of education to acquaint the people of the state with the dangers that result from the use of methanol. So far, there have been no deaths reported in Wisconsin from this anti-freeze mixture, but investigations which have been conducted in other states show the hazards, and we are taking time by the forelock to warn the people."

"Methanol is a volatile, cumulative poison," declares the bulletin issued jointly by the Wisconsin Medical Society and the American Medical Association. "When taken in frequently repeated small doses it induces blindness; in larger doses, whether by the stomach or lungs, it may cause death. The greater part of any quantity of methanol that reaches the lungs is absorbed and the dose sufficient to cause poisoning is not large.

"An investigator at the Harvard School several years ago compared the effects of ethyl alcohol and synthetic methanol (methyl alcohol) in a test on animals. Animals that received ethyl alcohol were less strongly affected by succeeding doses, whereas those receiving methyl became more deeply poisoned with each dose. After the third or fourth administration of a comparatively large dose the animals passed into a state of coma in which they died.

"The more highly developed nervous system of man is more seriously affected by methyl alcohol than is that of the lower animals, and permanent blindness has often been reported from single, sometimes small doses of methyl alcohol, whereas such results are unknown with ethyl alcohol.

"It has been asserted that synthetic methanol is not poisonous because it is a pure product. This is entirely erroneous since the truth is that in any preparation of methanol the toxic substance is the methanol itself.

"If, as now seems probable, methanol is widely sold for use in automobiles during the coming winter, and if precautions and warnings in regard to the dangers of inhaling its fumes from heated radiators are not instituted, it is highly probable that many cases of blindness will result and probably also fatalities. The public should be protected by law against its own ignorance of such matters."

CARELESSNESS

Madison, Wis., Dec. 17—If physicians were to record the most numerous expressions of the famous last words of persons who had been injured almost the uniform decision would be "I don't know." The educational Committee of the State Medical Society declared today that the phrase, "I don't know" causes more ruin to health and happiness than any other three words in the English language.

"I did not know that the gun was loaded," declared the boy whose sister was dead before him.

"Ducky Dickie Dennison didn't know that the bright little brass cylinder that slipped so snugly over the end of his pencil was a dynamite cap," continues the bulletin of the Medical Society in urging that people be more cautious in things they do.

"Dashing Dan Tucker came home late from a banquet of some sort and meant to take a dyspepsia tablet. He didn't know that someone had rearranged the bottles in the medicine cabinet, and that he really took ten grains of bichloride, but the coroner and the family have figured it out since.

"In any collection of famous last words you will invariably find at the top of the list, 'I didn't know that the train was coming,' 'I didn't know it was loaded,' and 'I didn't know that Imported Scotch was wood alcohol,' and the prize collection of bum alibies should begin, 'I didn't know she couldn't swim when I rocked the boat,' or 'I didn't know that Johnny's bad tonsils were liable to injure his heart.' "

"But then you can't reasonably expect Nature to stop the course of Time because someone doesn't know that it is time to get up. You can't expect her to suspend temporarily, the law of gravity because Bill Jones sawed the limb off between himself and the tree when he was trimming the orchard. It's our business to find out these things and behave ourselves accordingly. Ignorance of the law excuses no one.

"If you don't know that your children are in danger of diphtheria unless they are immunized, then this is to tell you that they are so. If you don't know enough to come out of the woods and be vaccinated against smallpox, it isn't the fault of the medical profession. If you don't know and abide by the Laws of Life, then you may expect the Laws of Disease and Death to assume jurisdiction. If you don't know how to take care of the body that God has given you—well, you will appreciate your health better after you have lost it.

"It's the things that folks don't know that will hurt them. It's things they don't know that kill."

CHRISTMAS DAY

Madison, Wis., Dec. 24.—"For the good of the children, it is better to spread the joys of Christmas over an entire week than try to center it all in a single day. Children who eat too much candy can create more disturbances in the household than any other single rumpus outside of a real sickness."

The State Medical Society of Wisconsin in its weekly bulletin today declares that the mother who gives more substantial attention to children and less things to eat will have more healthy children in the household. Christmas is the day when everyone thinks of the children because it means the birthday of the little Christ child.

"Christmas time will be a happier time if the excitement is not worked up to a pitch where the impressionable child will have a nervous reaction which may last for weeks," declares the bulletin. "A good play outdoors on Christmas day is even more essential on December 25th than any other day of the year. Get out into the open air with them,—play and run and make it a child's day.

"Healthy exercise in the fresh air and not too much indigestible food on this one day will make the day after Christmas, and the days to follow, happier ones for your children."

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(Continued from page 54)

soon come to utilize the certificate from this Board as a means of discriminating between those who are well grounded as specialists in obstetrics and gynecology and those who are not.

The Board does not intend in any way to interfere with or limit the professional activities of any duly licensed physician, but it does aim toward standardized qualifications for specialists in obstetrics and gynecology.

Any well qualified obstetrician and gynecologist should have no difficulty in obtaining a certificate and the Board is desirous of receiving applications from those to whom this applies.

The first examination for candidates will be held simultaneously in nineteen different cities of this country and Canada on Saturday, March 14, 1931.

Detailed information and application blanks may be secured from DR. PAUL TITUS, Secretary, 1015 Highland Building, Pittsburgh, Penn.

MEDICAL LIBRARY SERVICE

BIBLIOGRAPHIES

Do you have an unusual case which you plan to report before your local or state society or which you intend to publish in a current medical journal? The necessary historical background will be supplied through our bibliographic service. Often you have a rare case for which you may wish material on diagnosis or treatment for the last two or three years. This type of bibliography will be prepared also. The bibliographic service differs from the subject reference service in this way: When you ask for "material" or "selected articles", we choose for you journal articles or books on the subject which are in our library and forward that material to you immediately. When you ask for a bibliography you receive a complete list of all the articles in all languages that have been indexed for the years specified in your request. This gives you the opportunity to select your own articles and gives you an idea of the amount of work done in the field. Before we send you such a bibliography we check all of the articles which are available in our library. Any articles included in the bibliography which are not in our library will be secured elsewhere; for example, from the John Crerar Library in Chicago or from the Surgeon General's Library in Washington, D. C.

You may have a case of congenital absence of the radius with club hand and wish to know if other cases of this nature have been reported in the literature. We will send you every case of this nature that has been indexed by the American Medical Association and the Surgeon General's Catalogue. You may have a patient who seems to present a case of Christian's Syndrome and may ask us for a bibliography on the subject. Christian's Syndrome was first described in 1920; our bibliography will include all material appearing on the subject since the first article by Christian appeared in that year. The necessity for acuracy in such reference work is apparent. Our bibliographies are carefully prepared and proofed before they are sent to you so that all chance for error may be eliminated. An incorrect reference is worse than no reference at all; we make every attempt to have our bibliographies correct. The titles of the articles listed always appear in the language in which the article itself is written so that you may know before sending for the journal in which language the material appears.

There is no stated sum charged for this service. It is obvious that such a system would be impossible. In one case we might spend hours searching for references and find only two or three while in another case there might be thirty or forty references for each year. We are prepared to send you an estimate of the cost of the bibliography which you may wish to receive. In no case is the cost of such service at all prohibitive. Do not fail to profit by what others before you have done in a given field. Let us help you to become familiar with the more uncommon problems of the medical profession. G. B.

New and Nonofficial Remedies

In addition to the articles previously enumerated, the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Abbott Laboratories:
- Gold Sodium Thiosulphate–Abbott.

Eli Lilly & Co.:
- Erysipelas Antistreptococcic Serum–Lilly (Concentrated Globulin).

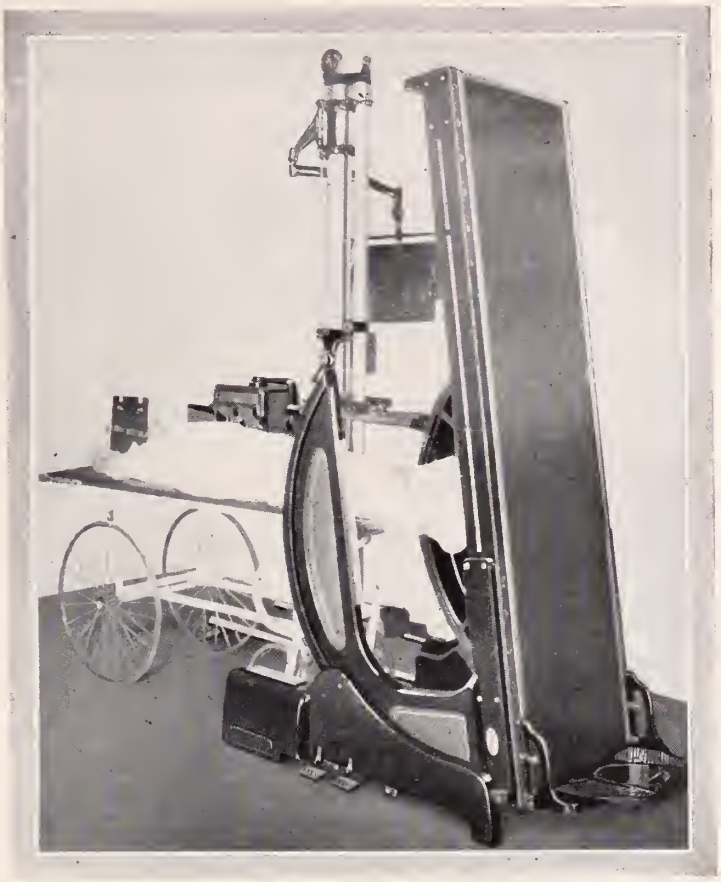
Medical Arts Laboratory, Inc.:
- Antirabic Vaccine, Semple Method.

National Drug Co.:
- Antipneumococcic Serum, Type I.
- Ointment Scarlet Red Biebrich 8 per cent.
- Typhoid–Paratyphoid A Vaccine.

Parke, Daivs & Co.:
- Ventriculin.

Richards Pharmacal Co., Inc.:
- Richards Psyllium Seed.

E. R. Squibb & Sons:
- Diphtheria Toxoid–Squibb, twenty 1cc. ampule packages.
- Diphtheria Toxoid–Squibb, two 1 cc. ampule packages.
- Normal Horse Serum, one 50 cc. vial package.
- Ragweed Pollen Allergen Solution–Squibb (3 vial treatment package).
- Timothy Pollen Allergen Solution–Squibb (3 vial treatment package).



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VOLUME XXX
NUMBER 2

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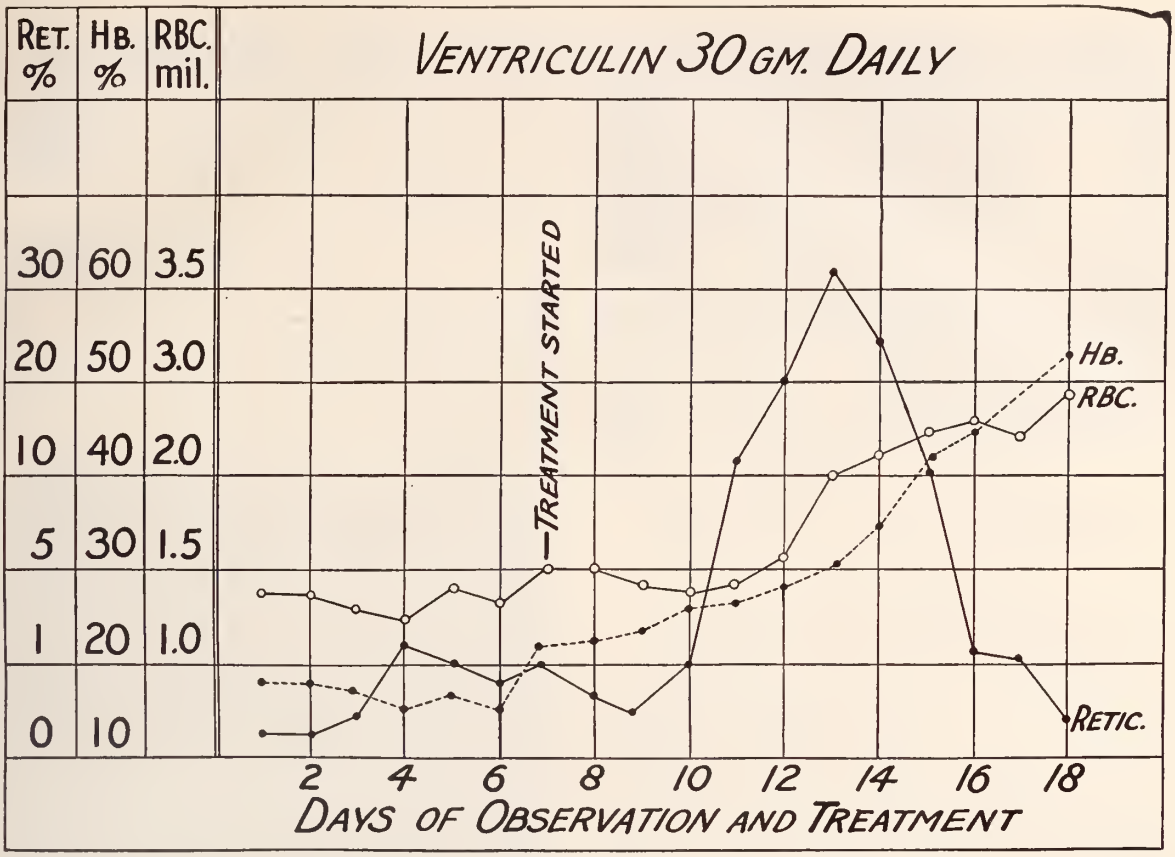

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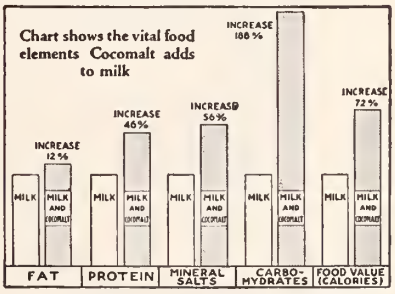

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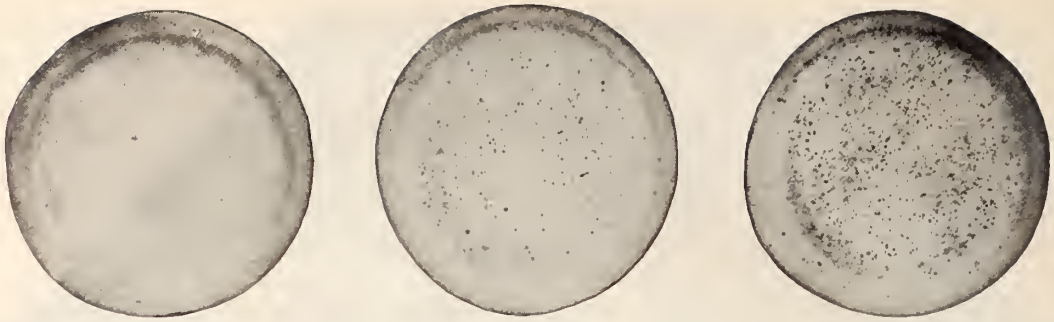

1. DEXTRI-MALTOSE 2. TWO CARBOHYDRATES OF LESS MANUFACTURING EXPERIENCE—3

PHOTOGRAPHS OF TYPICAL FILTER DISKS AFTER SEDIMENT TEST
(These are not Petri-dishes. The bacteriological cleanliness of Mead's Dextri-Maltose is a *separate* test.)

The outside ring in each case represents the crimping action of the rim which holds the cotton disks in the sediment tester. The dark areas are shadows which have no significance. But the little black spots are of the utmost significance to the doctor who feeds babies; they represent particles of debris which, when added to the milk, undo the most rigid sanitary control and inspection at the dairy.

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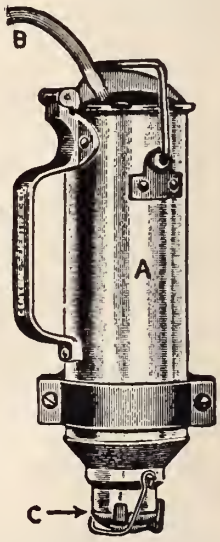

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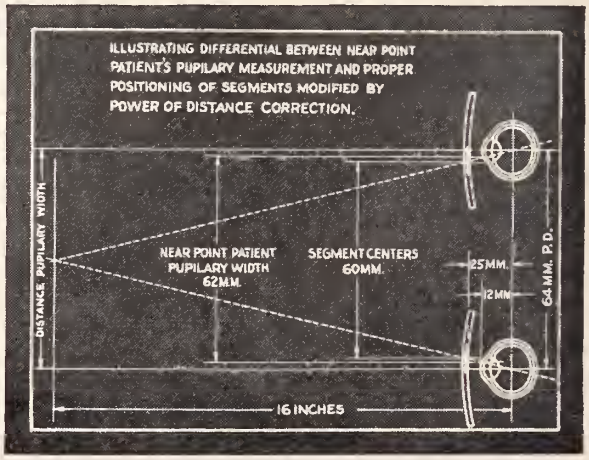

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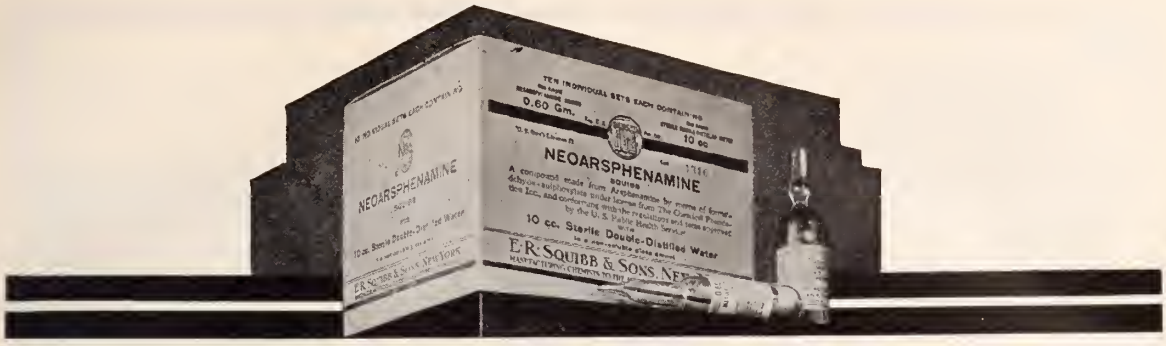

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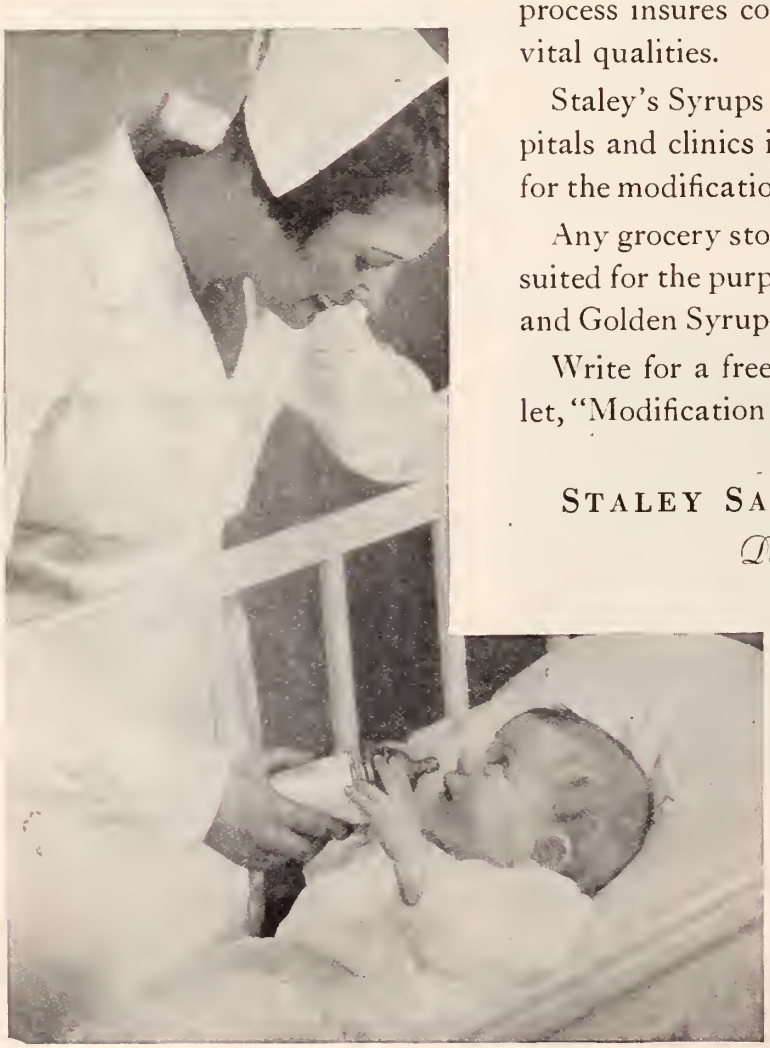

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The Wisconsin Medical Journal

Volume XXX MADISON, WIS., FEBRUARY, 1931 No. 2

Complications and Sequelae of Pulmonary Infections*

By W. J. EGAN, M. D.
Milwaukee

The subject of the therapeutic management of the complications and sequelae of pulmonary infection has been particularly interesting to us because of the variety of cases that have presented themselves this last year. This problem is no longer one between the physician and patient only, as in former years, for we now need the assistance and cooperation of the roentgenologist, surgeon, and of the oto-rhino-laryngologist with good bronchoscopic technique. In that a complete discussion of this subject is manifestly impossible, in the time allotted, we will consider the various plans of procedure and facilities available for only the more common pulmonary lesions.

PLEURITIS

Pleuritis, common in our state, is usually secondary, rarely idiopathic, and should be considered tuberculous, particularly in adults, until proven otherwise. Do not be misled by an apparent early recovery of a patient, for a definite parenchymatous tuberculous lesion may be present at the outset of pleurisy, be absorbed and cause us to be too optimistic.

Bezaven states that pleurisy at adolescence will often have revealed the impregnation of tuberculosis and it will only be a few years that pulmonary disease will manifest itself.

Malony, in 1000 cases of adult tuberculosis, reported an average interval between the first known symptoms and the ultimate breakdown of two and one-fourth years.

Webb reports a history of pleurisy in 650 out of 2,123 patients who developed tuberculosis.

Gaarde and Graham each maintain that pleurisy with effusion deserves the same consideration as that given pulmonary hemorrhage. Our prognosis should be guarded in all cases and grave in those in which a positive guinea pig inoculation test is obtained.

These cases are to be kept under observation, questioned as to symptoms frequently, examined frequently, and subjected to repeated x-ray and fluoroscopic study. They are not to return too early to work and must lead a careful hygienic life with supervision of all activities, regulation of exercise and posture—in short—the regime usual for tuberculosis, with particular attention to the establishment of their normal weight.

Small pleural effusions are usually not disturbed, for they are frequently absorbed, and are frequently beneficial, due to compression to their hosts.

Large effusions are rarely absorbed, may become purulent, and tend to form adhesions. They should be removed by paracentesis with gas or air replacement. It is dangerous to remove more than 1000 c. c. at one time and aspiration may be safely repeated provided the effusion harbors no secondary organism.

Adequate care of pleuritis will certainly obstruct the extension of the original infectious process in many, and will tend to prevent the formation of adhesions, with their attendant ill effects upon the lungs, making possible, if the necessity should arise, the better accomplishment of a satisfactory artificial pneumothorax, phrenic exeresis, or thoracoplasty.

BRONCHIECTASIS

Bronchiectasis is not infrequently seen following pneumonia, recurrent pulmonary infections, sinusitis, foreign bodies, measles, scarlet fever and whooping cough. With our ever helpful radiological colleagues and and the introduction of Forestier of lipiodol or similar compounds, it is now possible for us to recognize early bronchiectasis with much greater facility.

* Presented before 89th Anniversary Meeting, State Medical Society of Wisconsin, Milwaukee, Sept. 1930.

Every effort to remove any causative factors in early bronchiectasis should be made to prevent permanent structural bronchial damage. The usual general treatment should be instituted, search made for foci of infection, correction if possible, and careful search for foreign bodies. No case of this type is properly managed unless a thorough study of all sinuses is made for possible points of continuous infection and aggravation, for sinusitis is frequently quiescent.

Hedblom, who considers bronchiectasis, next to tuberculosis, the most frequent pulmonary complication, has perfected the operation of graded extra-pleural thoracoplasty. Graham reports favorable results by a cautery, pneumonectomy in refractory bad risk cases. Whittemore has improved upon the Lockwood operation of lobectomy—which lobectomy seems to be the goal of thoracic surgery because it is non-deforming and certainly diminishes the period of convalescence. We medical men must grant that surgical technique is being perfected tremendously, with a striking reduction in mortality even in the most severe cases, which cases, up to recently, have been the only cases presented to our surgical colleagues.

Hedblom considers that drainage, either postural or by bronchoscope, is the treatment of choice in cases of single cavitation or of localized gangrenous extension.

Also, that phrenic exeresis and graded extra pleural thoracoplasty should be instituted in cases of long standing. The usual result of his cases has been a marked improvement approaching a symptomatic cure, with a relatively low mortality. The results of artificial pneumothorax have been disappointing because of pleural adhesions and pulmonary adhesions preventing a satisfactory collapse.

EMPYEMA

Having lived through the days, at Ann Arbor, of admission to University Hospital of many unrecognized and late empyemata; later at Ft. Riley where far too many unrecognized and untreated empyemata arrived at their ultimate destination; later, at Base Hospital No. 22, during the fall of 1918, where we, for a short time only, saw the fatal results of too early operation, we are now in an era of intentional procrastination due to dependence, altogether too frequently, upon "pin hole" drainage by repeated paracentesis instead of adequate drainage by other means.

It is true, as McEnery states that operation for empyema is not one of emergency. Wilensky, in 200 cases, reports a lessening in the mortality rate with each week that operation was delayed up to the seventh or eighth week from the beginning of the disease, after which the mortality rate showed a rapid rise.

As Funk states, "delay in the free evacuation of the purulent exudate, if not fatal from local extension or septicemia, is harmful because of the extensive fibrosis of the pleura and adjacent lung which may follow even small effusions. Ultimately the clinical picture may be that of marked pulmonary fibrosis.

The facilities for drainage are: 1. Paracentesis. 2. Method of Hart of tidal irrigation and suction. 3. Intercostal incision. 4. Rib resection.

In streptococcic empyema, in which the exudate is thin, serofibrinous and forms adhesions slowly, aspiration is done daily or every other day, until the exudate becomes thick before operation and drainage. Sudden removal has been fatal in the past due to collapse of the lung, septicemia, or shock from mediastinal flutter or recession.

The exudate in penumococcic empyema walls off quickly and operation may be done promptly. If the effusion is too large, aspiration with gradual removal of most of the exudate is done prior to incision and drainage.

According to Funk, failure of drainage to cease and the incision to heal are due to:

1. Inadequate drainage.
2. Tuberculosis.
3. Osteomyelitis (of rib)
4. Foreign body.
5. Failure of lung to expand and fill space occupied by pleural exudate in a case of long standing with thickened pleura.

6. Eggers cases in which early opening and drainage is followed by fixation of the lung in the collapsed state.

In addition to the usual general after care of these cases, insistence upon exercise and training to regain proper posture, will prevent many deformities.

TUBERCULOSIS

The management of tuberculosis no longer is a matter only of rest, outdoor life, nutritious food, heliotherapy, et cetera. It has become a more active problem for we practitioners to face and much more is expected of us than in former years. The mortality is still high and, as Lotz states, in most of the institutions not limiting their admissions, the rate of advanced cases varies from eighty to ninety per cent.

Before discussing therapeutic methods at our disposal, may I be permitted to digress for a few minutes. May I call your attention to the fact that since 1922 Assmann, Redeker and innumerable continental physicians have assailed our old concept of the incipiency of apical tuberculosis.

They have called attention to the lesion variously designated as the "Assmann focus", "subapical infiltration", "infraclavicular infiltration", "early infiltration."

Assmann states, "Its most frequent localization is the infraclavicular region, but any other part of the pulmonic fields may be affected, apical localization being extremely rare. Clinically, its appearance is accompanied by a sudden onset of mostly very slightly catarrhal, grippe-like symptoms. In a number of cases no symptoms are noted. The temperature may or may not be elevated; the pulse is usually increased. The important point is that its symptomatology bears no resemblance whatsoever with the text book symptoms of "incipient tuberculosis." Cough is frequently absent in the beginning; the symptoms, slight as they may be, do not begin insidiously; lassitude, fatigue, backache, night sweats, loss of weight, all these are symptoms of a later stage. The physical signs are so uncharacteristic—frequently absent according to competent observers— that a correct diagnosis cannot, in some instances, be made without x-ray studies. This lesion contains all the potential sequelae of pulmonary tuberculosis. It may resorb so completely as to leave no roentgenological mark; it may caseate and excavate, giving rise to a usually spherical, isolated cavity (the Frühkaverne of the German authors) ; it may give rise to bronchiogenic mestatases (Ausstreuungstuberkulose) ; it may, by way of the two last-mentioned possibilities, develop into a progressive and destructive fibrocaseose tuberculosis, which, in its turn, usually progresses downward.

In this country Douglas, Pinner and Walepa summarize their extensive work as follows:

1. Progressive and destructive pulmonary tuberculosis usually begins suddenly, with exudative subapical lesions.
2. Strictly apical productive tuberculosis is not, as a rule, the incipient stage of progressive and destructive pulmonary tuberculosis; it may precede the latter; but even in such cases the latter starts usually as stated under No. 1. The role which apical tuberculosis plays in phthisogenesis is rather insignificant as compared to that of acute subapical infiltrations.
3. Lesions far advanced as to extent, and excavations, frequently develop within less than six months.
4. Processes leading to active progression and to excavation are most frequently associated with acute symptoms.
5. Apical involvement is, in the majority of patients, not an occurrence of incipiency but of a late development.
6. Physical signs and symptomatology, traditionally described as characteristic for "incipient pulmonary tuberculosis," are misleading for the detection of truly incipient subapical acute processes.
7. Diagnostic and therapeutic endeavors must be directed primarily toward acute, subapical processes, and not toward the insidious apical disease.

ACTIVE TREATMENT

These concepts rather plainly indicate that we are not to rest content with ordinary passive treatment of our patients as soon as the diagnosis of pulmonary tuberculosis is made.

Instant institution of active treatment at home or sanatorium is to be established, with precaution against neglect of our patients while they are on the waiting list of a sanatorium.

We shall consider hurriedly the various means for our use in pulmonary tuberculosis in a didactic fashion, not with the idea of completely covering them all, but with the idea of giving us something to think about.

Transfusion has been of tremendous advantage to us. I shall quote Dr. Yates verbatim:

"Unmodified blood has been given with paraffined tubes. Many patients have received one, some three or four, and a few seven or more transfusions.

"Indications—Serious blood deficits, preparation for operation, post-operative hypotension, and incipient acute pneumonia, especially in the less affected lung, are indications for transfusion.

"Contraindications.—Transfusion is contraindicated in the presence of irrevocable incompetence in the blood-forming structures or in the heart muscle.

"Failures.—Once the capacity to form cellular or noncellular constituents of the blood is lost or if myocardium is irreparably damaged, transfusions, no matter how often repeated, are futile though they may prolong life for a few weeks or even months."

Therapeutic pneumothorax according to Funk is indicated:

A. Fairly extensive unilateral disease with little or no involvement of the other lung.

B. When definite improvement under strict hygienic dietetic care has not occurred from 6 to 12 weeks.

C. In any patient in whose hemoptysis is persistent when the side from which the bleeding comes can be determined. It is frequently life saving in case of profuse pulmonary hemorrhage.

Pleural adhesions may hinder and when extensive may entirely prevent pulmonary collapse.

Contraindications.—a. Extensive, rapidly advancing bilateral tuberculosis.

b. In presence of advanced cardiac or renal diseases.

c. When there is present a serious extrapulmonary tuberculous lesion, which of itself is sufficient to prevent recovery.

Induced paralysis of the diaphragm by interruption of the phrenic nerve is being used universally. To quote Yates again:

"Indications.—Temporary paralysis is used for incipient lesions and moderately advanced lesions which are of such nature as to indicate probable healing in four months or less and a return of motion will be helpful in restoring vital capacity, for recurrent hemorrhages from pulmonary artery and for pain. Permanent paralysis is induced as a preliminary step to thoracoplasty if return of motion is undesirable.

"Contraindications.—Immobilization, high position and fixation of the diaphragm by dense adhesions over the lower lobe, immoderate susceptibility revealed in irremediable blood deficits, and approaching death are contraindications for produced paralysis."

THORACOPLASTY

"Indications.—Existence of cavities that cannot collapse because their walls are too rigid or because they are fixed by pleural adhesions to parietes demands thoracoplasty to provide opportunities for arrest of the disease or recovery from it. Limited thoracoplasty is indicated if the cavitation is restricted to an upper or a lower lobe and the balance of the lung is so little affected that it can recover and contribute to external respiration and other pulmonary functions. Complete thoracoplasty is indicated if cavities exist in more than one lobe or if they are confined to one lobe and the lesion in the balance of the lung suffice to have destroyed its capacity to regain function; if incomplete, thoracoplasty fails to promote arrest or recovery.

Contraindications.—Loss of blood-forming powers, pronounced and irreparable myocardial incompetence, progressive bilateral lesions and lack of morale are included in the contraindications."

DISCUSSION

Dr. T. L. Harrington, Milwaukee: Dr. Egan says, "If the effusion is small let it alone. It seems to have a beneficial effect on the case." I agree with him in that, but he says further, "If the effusion

is larger withdraw it, because of the danger of future adhesions or the danger of a pyothorax."

I wish he were a little more definite in stating what is meant by "larger effusions." I will agree with him that if the effusion is sufficiently large so that the heart is being displaced, then some of the fluid should be withdrawn, but if the heart is not displaced, if breathing is not embarrassed and there is no cyanosis, your patient will usually do better to let the effusion alone.

Regarding the adhesions, if you get adhesions following an effusion of considerable size, but not sufficient to displace the heart, you get only what you are likely to get after withdrawal. After withdrawal, even though air takes the place, or a gas, you are almost certain later to get adhesions, and I believe that is a minor matter.

I wish we might teach the general practitioner in Wisconsin that pleural effusion, unless complicating a pneumonia, is almost always tuberculosis, and that there is in practically all cases, except in the cases where there is marked embarrassment of respiration or displacement of the heart, greater danger to the patient in withdrawing the effusion rather than in letting it alone. Repeated aspiration may lead to a pyothorax with a mixed infection, and when this occurs both patient and physician are "out of luck." If the hydrothorax becomes a pyothorax without a mixed infection, it can usually be cleared up by one or more aspirations with a large sized needle.

Dr. A. L. Banyai, Wauwatosa: I would like to mention a few points in connection with the diagnosis and treatment of non-tuberculous chronic pulmonary conditions. One of the most important points which bears emphasis is that we should prolong the convalescence of all patients with acute respiratory disease. We should be just as careful with those patients as we are at present with patients suffering from rheumatic heart disease. It is frequently seen that if the patient gets up too soon, as was emphasized by Dr. Egan, he is liable to develop a pulmonary fibrosis which in turn is followed by bronchiestasis. Therefore, it seems to me, it should be made a rule that the patients with acute respiratory disease should be kept in bed until all constitutional and local symptoms disappear; also until the vital capacity and the excursion of the diaphragm on both sides becomes normal.

Five years ago I had the opportunity to make a special study of non-tuberculous pulmonary conditions, and I found it a very interesting phenomenon that when you analyze the x-ray of a patient with this condition you do not find any gross pathology, yet the film does not look normal. It was also noticed that the basal linear markings show a beading which is a very helpful aid for the recognition of this condition, particularly so if one does not have the opportunity to inject lipiodol.

I have had the opportunity to treat quite a few cases of bronchiectasis by artificial pneumothorax. The results were highly satisfactory. Just recently I had under my observation a patient with a very extensive bronchiectasis on the right side, of unknown etiology, who also had a very marked clubbing of the fingers and toes. Following a few months' treatment of the pulmonary condition by artificial pneumothorax, a very interesting phenomenon was observed,—the clubbing of the fingers gradually disappeared.

Another point of interest is, that, since January of this year, bilateral pneumothorax has been given at Muirdale Sanatorium, and our results so far have been very satisfactory. I have a patient who, after taking a bilateral artificial pneumothorax and having a vital capacity of 750 c. c., gets up from the operating table and walks out of the room unassisted.

Dr. Egan: It was obviously impossible to go into detail in the treatment of pleural effusion. We know we have to remove it for cardiac embarrassment. If we do not, some one else will.

As to what constitutes a large effusion or a small one, Dr. Harrington's experiences and observations would be worth more than mine, because he travels extensively throughout the state. We saw an unfortunate number of cases last year. We saw Dr. Alexander operate four abscesses in one morning, due to the fact that they were neglected. We are taught, whether it is true or not, that they become purulent. For that reason, it was considered that they should be removed.

One of the most important things to do with acute pleurisy with effusion or arrested cases of tuberculosis or suspected cases is to put them to bed when they have acute colds. They should be kept in bed for twenty-four or forty-eight hours or until the temperature is normal, as if they were tuberculous.

MEDICAL GRIEVANCE COMMITTEE

In accordance with recommendation of the Council of the State Medical Society of Wisconsin at its January meeting (see page 113) Senator Walter Hunt of River Falls has introduced bill number 58 S establishing a state medical grievance committee.

Under terms of the bill suggested by the State Society, the committee will be composed of the Attorney General, or the Deputy Attorney General, the Secretary of the State Board of Medical Examiners and the Secretary of the State Board of Health. The Secretary of the State Board of Health will act as chairman of the committee. The committee will have the power to issue subpoenas and to investigate such practices as are inimical to the public health.

The medical grievance committee plan was first established in New York state and the Wisconsin committee is modeled, in its thought, after the New York law. The senate committee on education and public welfare had a hearing on this plan on Tuesday, February 3rd.

Convalescent Serum Therapy*

By J. E. GONCE, Jr., M. D.
Madison

Although there are several different diseases in which convalescent serum has been suggested and tried in the way of prevention and treatment, there are at the present time two diseases only, measles and poliomyelitis, which, from practical experience, deserve consideration.

Of these two diseases the more uniform results from the use of convalescent serum have been obtained in measles. The original idea of the use of convalescent measles serum for the purpose of immunizing children against the disease dates back 200 years ago to Home of Scotland; but there was very little practical application of it before 1916 at which time the idea became popularized by the reports of Nicolle and Conseil, and also of Parke and Zingher. Since 1916 so much experience has been had with this method of immunization that it now may be said with authority that the blood serum taken from the measles convalescent 5 to 7 days after return of normal temperature is so rich in antibodies that it will absolutely prevent the disease upon subcutaneous injection in sufficient amounts into the individual early after exposure to measles, and that it will, upon injection in sufficient amounts into the individual late in the incubation period, greatly modify and ameliorate the course of the disease. There seems to be some question as to the benefits to be derived from the use of convalescent measles serum after the symptoms of the catarrhal stage have developed, but it is thought by some workers that even under such circumstances the subcutaneous injection of large amounts, such as 25 to 30 cc. of convalescent serum, does reduce the severity of the disease. However, everyone is agreed that 6 cc. of convalescent serum given to children under 3 years, and 6-10 cc. to the child over 3 years, when given within 1 to 3 days after exposure to measles, will prevent the disease and confer a passive immunity to measles lasting anywhere from one to three months. Such a protection is of inestimable value to infants exposed to measles, infants being, as they are, subject to such serious complications of the disease. This applies as well to sickly older children. There does not seem to be much reason for conferring a temporary passive immunity in healthy older children by the use of convalescent serum, but there is good reason for modifying the course of the disease in such children by giving the serum late in the incubation period. If 6 to 7 days are permitted to elapse after exposure, 5 to 10 cc. of the serum may be given with the confidence that the disease will develop in a very mild form. This method of procedure has the further advantage of permitting the child to develop its own active (a permanent) immunity to the disease.

A very important feature in the use of convalescent serum, of course, is the necessity of excluding the possibility of syphilis and tuberculosis in the donor. In this respect it should be kept in mind that the Wassermann test is frequently positive in measles as an artefact staying positive for about 5 days after the return of normal temperature.

Another matter of some importance is that pooled serum from several convalescents seems to be considerably more potent than serum from a single convalescent. Frequently as little as 3 cc. of pooled serum given to infants and young children within 2 or 3 days after exposure proves sufficient to prevent the development of the disease.

Still another matter of considerable importance is concerned with the relationship between the age of convalescent serum and its potency. That is, how long does it keep outside the body? From practical experience it may be said that convalescent measles serum preserved with 0.5% phenol and kept on ice in ampules probably loses most of its power to confer passive immunity in about 3 months. In this connection it is interesting to note that Burnet of Melbourne in 1929 reported a very carefully controlled experiment proving that serum

* Presented before Ninth Councilor District Society, Wausau, Nov., 1930.

from poliomyelitis convalescents when obtained by treatment of the whole blood with oxalate and filtration and having no antiseptic added, retains its virucidal qualities for at least 3 years when kept in ampules at ice box temperature.

One of the biggest disadvantages connected with convalescent measles serum is its inaccessibility to the general practitioner and its scarcity. Naturally, the mother does not like to have her child bled, especially during convalescence, and even when the mother is willing the physician does not feel justified in removing a large enough amount of blood from a child to make it worth his trouble in securing the 35% of serum it yields by the coagulation method. Consequently it is necessary to depend upon adults for the supply of blood, and with measles, essentially a disease of childhood, the opportunity of getting donors is infrequent in occurrence.

SERUM OF ADULTS

Because of these difficulties of obtaining convalescent serum the question naturally rises as to whether or not the serum or whole blood of adults, who have had measles some years previously, will act just as effectively as the convalescent serum in the protection of exposed persons. And in putting this question to the test during the past few years, it has been definitely established that such serum or blood is almost as dependable as convalescent serum in preventing and modifying measles, provided large enough amounts are given. One of the most recent reports on this phase of the subject is by Boden, who states that in a series of 30 exposed children, varying in age from 6 months to 4 years, in whom intramuscular injections of 20 to 30 cc. of the whole blood of persons recovered from measles 2 to 25 years previously were given within the first seven days following exposure to measles, the blood completely protected 12 patients, and was followed in 9 by a modified and attenuated measles without catarrhal symptoms. In 8 patients mild catarrhal symptoms were present. One child had measles of moderate severity and was the only one of the 30 to have Koplik's spots and a typical eruption. No complications occurred in any of the children. Consequently it would appear from this report, and from many other reports to the same effect, that the position of the general practitioner is much simplified in preventing and modifying the course of measles. When he has an exposed child under 5 years, the age group in which 90 per cent of the deaths from measles occur, or an exposed child of any age suffering from other illness in whom it is especially desirable to avoid the measles, all that is necessary for him to do in order to prevent or greatly ameliorate the severity of the disease is to take 20 to 30 to 40 cc. of whole blood from either parent who has had measles sometime in the past, and immediately inject it into the child's buttocks. The earlier after exposure up to 6 or 7 days the more sure is the disease to be prevented.

POLIOMYELITIS SERUM

Although convalescent measles serum can be used with almost mathematical precision the same can by no means be said of convalescent poliomyelitis serum. However, in the past few years very encouraging results have been obtained by the use of convalescent poliomyelitis serum, and it is regarded by those who have had the most experience with it as being a therapeutic agent of definite value. Unlike convalescent measles serum it has not been used for the purpose of conferring a passive immunity because the immune bodies, when injected subcutaneously, or intravenously are thought not to pass through the normal choroid plexus into the cerebrospinal fluid, and because the intraspinal injection of serum, and even lumbar puncture, is thought to reduce the meningeal-choroid plexus complex defence. Instead, convalescent poliomyelitis serum has been used intraspinally, intravenously and intramuscularly as a therapeutic measure in the preparalytic stage of infantile paralysis.

From the experimental standpoint there is no doubt but that convalescent serum should be of great value in the treatment of infantile paralysis in the preparalytic stage. By experiments with monkeys it has been conclusively demonstrated by many different investigators that the blood serum of both

humans and monkeys convalescent from infantile paralysis neutralizes the virus of infantile paralysis both in vitro and in vivo. A mixture of convalescent serum and virus emulsion inoculated intracerebrally into monkeys does not result in the development of infantile paralysis whereas the virus emulsion alone injected intracerebrally results in the development of the disease in about 5 days. If the intracerebral injection of virus is followed in a few hours, up to 24 hours, by the subdural injection of convalescent serum, the appearance of the disease is prevented, greatly delayed or modified. If a subdural injection of convalescent serum is given first, protection against intracerebral injection of virus will be conferred for 2 days, and against local inoculation of the virus on the nasal mucous membrane for 4 days. This property of neutralization of the virus by convalescent serum is also frequently present in the serum of persons who have been in contact with definite cases of infantile paralysis without developing it. It is, then, an experimental fact that convalescent serum and serum from persons who have been in contact with the disease without developing it neutralizes the virus of poliomyelitis.

In addition, experimental evidence indicates that in gaining entrance to the body the virus deposited on the mucous membrane of the nose passes along the fibres of the olfactory nerves and thence, by breaking down the meningeal-choroid plexus complex defence, enters the cerebrospinal fluid. Having once gained entrance into the cerebrospinal fluid the virus then quickly passes into the tissues of the brain and cord and within a short time causes the development of paralysis.

During the process of penetration of the meningeal-choroid plexus complex defence signs of meningeal irritation appear which are quite characteristic to both clinical examination and examination of the cerebrospinal fluid. To this period the term preparalytic stage is applied. Clinically this period usually lasts about 3 days and represents the interval elapsing between the onset of illness and the appearance of paralysis. The symptoms and signs at this time (preparalytic stage) will consist of fever, which is rarely high, headache, drowsiness when the child is left alone, and irritability when it is disturbed, pain in the neck and back, stiffness of the neck and back, general or local hyperaesthesia and perhaps tremor of the hands, localized sweating, photophobia and retention of urine. Stiffness of the neck and spine is usually slight and never as marked as in tuberculous or cerebrospinal meningitis. It is often so slight as to be missed by the examiner unless specifically looked for. Its detection is often impossible with the child in the supine position by the ordinary method of placing the hand under the head and moving it forward. Instead, it is necessary to hold the child in a comfortable position and ask him to kiss his knee whereupon, when the sign is positive, the child after commencing the action refuses to complete it because of pain in the back. Another method of eliciting this sign is that described by Amoss. When the child is placed in a sitting posture upon a firm surface, such as a table or chair, the position assumed is that of a tripod, the child conveying part of the weight of the body through the arms in order to ease the pain in the back. The presence or absence of this sign may also be demonstrated by raising the child from the recumbent position with the examiner's hands placed under the buttocks and shoulders. When the sign is positive the child will not hold his head in the horizontal plane with the body but instead, on account of pain, will permit it to fall back.

Examination of the cerebrospinal fluid at this time (preparalytic stage) will show increased pressure, slightly opalescent appearance, increased number of cells (30 to 70 per cubic millimeter), of which there will be a preponderance of polymorphonuclear leukocytes, possibly an increase in globulin content, and a Lange curve of almost 0112100000. As the preparalytic stage advances toward the paralytic, the proportion of the polymorphonuclear cells falls and that of the mononuclear cells increases.

It is in this, the preparalytic stage, that the most beneficial results are to be expected from the use of convalescent serum because at this time, before damage to the nerve cells

has taken place, it is possible, at least theoretically, to neutralize or destroy the virus and prevent injury to the nerve cells. Later when paralysis has occurred nothing can repair the injured nerve cells although it is possible that convalescent serum might prevent further paralysis.

Theoretically then convalescent serum given in the preparalytic stage should be of great value in the treatment of infantile paralysis. How does this experimental fact compare with clinical experience? Although opinions differ, an analysis of various reports shows that convalescent serum is of distinct value in the preparalytic stage of infantile paralysis, both in preventing the development of paralysis and in diminishing its severity if it does develop. Analysis of the reports indicating favorable action of convalescent serum shows that paralysis does occur in the majority of cases after the use of the serum in the preparalytic stage, but that the extent and severity of the paralysis is not as great as in the untreated cases. For example, by the scale used by the Harvard Infantile Paralysis Commission the grade of paralysis was 63.6 in the untreated cases as against 19 for the paralyzed treated cases. The conclusions of Aycock and Luther of Boston are that their clinical experience indicates "a favorable effect of convalescent serum when administered in the preparalytic stage of poliomyelitis, as shown by: (1) A low mortality rate, (2) A low average total paralysis, and (3) A strikingly low paralysis of the severer grades."

ADMINISTRATION

As to the route of administration it would seem that inasmuch as the convalescent serum must reach the cerebrospinal fluid in order to do any good, it should be given directly into the spinal canal. However, it is quite well established that the serum given intravenously or intramuscularly is able to gain entrance into the cerebrospinal fluid because of the alteration of the meningeal-choroid plexus complex defence brought about by the virus. As a matter of fact, Shaw, Thelander and Fleischner have reported satisfactory results by treatment with intramuscular injection of serum. Consequently it would seem desirable in the treatment of infantile paralysis in the preparalytic stage to complement the intraspinal administration with an intravenous or intramuscular injection of serum. By clinical experience it has been determined that an effect dose consists of 10-30 cc. of serum intraspinally and at least an equal amount intravenously or intramuscularly. Macnamara of Melbourne recommends a total amount of at least 60 cc.

A very important consideration in respect to serum therapy of infantile paralysis is the necessity for the administration of the serum at the time of the first lumbar puncture. Both experimental and clinical experience have shown that lumbar puncture lowers the resistance of the meningeal-choroid plexus complex defence to the extent that the invasion of the cerebrospinal fluid and nervous tissue by the virus is greatly facilitated and accelerated. The greater the delay, then, between lumbar puncture and serum administration the less the possibility of neutralization of the virus by the serum.

For the same reason it is imperative that the administered serum be actively immune. Otherwise the damage to the meningeal-choroid plexus complex defence may result in infection of the central nervous system being promoted. The only exact method of determining the presence of actively virucidal properties in serum is by animal experimentation with monkeys, but inasmuch as there are very few laboratories equipped to carry out such a test it is necessary in most instances to resort to simpler methods in assuring the certainty of the activity of the serum. This may be done with a reasonable degree of accuracy. As it is a well proven fact that the blood of the poliomyelitis convalescent is rich in virucidal properties the most important step in setting out to obtain actively immune serum is to select donors in whom the diagnosis of recent infantile paralysis is unquestionable. The next most important item is to so separate the serum from the whole blood and to so preserve it that its activity will be retained for long periods. The requirement of the proper selection of the donor should present no difficulty. Furthermore, it is not

essential that he (the donor) be recently convalescent because it has been shown by Burnet of Melbourne that the blood of persons who have had infantile paralysis as long as 3 years previously still retains its virucidal properties. Beyond that period of 3 years the blood of the persons previously affected with the disease is probably actively virucidal as in measles, but there is no experimental work to prove it. The proper separation and preservation of the serum can be easily carried out by any modern laboratory. The procedures, as proven by Burnet, to give a serum of unaltered potency consist in "preparing the serum from oxalated plasma according to the methods used with commercial horse antisera. Sterility is assured by the use of a rigidly aseptic technique and filtration through porcelain candles. The product is finally sealed in ampules without added antiseptic and left stored at ice box temperature." The virucidal properties of serum prepared and preserved by this method are retained for at least 3 years. No doubt serum separated from whole blood which has been permitted to coagulate is just as active as serum prepared by the method described by Burnet.

The use of convalescent serum in the treatment of infantile paralysis in the preparalytic stage then, is based on sound experimental and clinical evidence and warrants extensive use.

Irritable Bowel*

By JAMES E. McLOONE, M. D.
La Crosse

The symptom complex which I shall term irritable bowel presents itself about as frequently for correction as any one other digestive disturbance. Kantor[1] makes the statement that fifty per cent of all digestive disturbances are of this nature. In spite of this fact the condition frequently goes unrecognized. The individual instead is subjected to operation; most frequently for chronic appendicitis and occasionally for gall bladder disease. It must be admitted, however, that an irritable bowel may accompany either of these conditions mentioned and be secondary to them. The importance of recognizing this condition is paramount, because patients with this complaint are frequently made worse by this unnecessary surgery. Again, this condition is attributed to malfunction of the stomach, most commonly ulcer, and the individual so labeled made a poor insurance risk, if no greater harm done. The mechanism of this colon irritability or spasm is explained on the basis of a vagotonia, associated with stimuli, abnormally affecting the vegetative nervous system.

Recalling the anatomical outlay of the gastro-intestinal tract, it is remembered that the muscular layer is the largest of the three coats, and consists of an inner circular and outer longitudinal portion. It has a double nerve supply. The sympathetic fibers for the colon and rectum originate in the lower lumbar region and stimulation of these reduces the tone of the musculature and inhibits motion or peritalsis. The parasympathetics (which are physiologically equivalent to the vagus nerve) are supplied through the pelvic nerves and stimulation of these increases the tone of the musculature and renders active peristalsis. Sacral fibers from the latter are in connection with ganglion cells located between the circular and longitudinal coats of musculature constituting the plexus of Auerbach. Normally, the mucous membrane of the colon is kept moist by secretion of mucus aiding in the passage of feces and reacts so to chemical and physical stimuli. Similarly to other hollow organs of the body, the motor functions of the colon depend upon tone and peristalsis,—the two being mutually independent. Thus peristalsis may often be active in the presence of decreased tone or vice versa. The lumen of the gut depends on this tone and the amount of feces and gas therein. Thus pathological distention of lumen or marked contraction of the gut can, by its

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nerve supply, give rise to pain or distress in the region involved or it may be referred.

The secretory mechanism of the bowel is controlled by the same nervous system and likewise is affected if this system becomes disordered. Gilbert[2] feels that mucous membrane function may likewise be disturbed by an associated prolonged hyperkinesis. Many writers consider spastic colitis and mucous colitis merely two stages of the same disease.

ETIOLOGY

The causes of irritable bowel or spastic colitis, although the condition can hardly be called an inflammatory one, may be divided into two groups, the extrinsic and intrinsic. Under the first group are those individuals commonly termed neurasthenic, the greater part of whom are women. Some writers[3] feel that an unstable nervous mechanism is the basic cause in a great number of individuals with this complaint. Smithies feels that these people present a peculiar diathesis,—a spasmophilic tendency, present from birth and evidenced by colon upsets, on an allergic basis. A colitis is then the rêsult instead of asthma. Other extrinsic factors are chronic appendix, gall bladder disease, right sided adhesions, pelvic conditions and acute respiratory infections.[4]

The intrinsic causes are dietetic, bacterial, parasitic and conditions locally affecting the anus and rectum such as hemorrhoids, fissures and proctitis.

Personally, I feel that more than physiotherapy or vaccines are necessary to correct this condition, and other men[5] stress this point considerably.

I feel that the mode of living and eating of the present generation with the rush and hurry of daily routine, lack of regular meals, proper foods and daily bowel evacuation contributes greatly to this condition. In fact, it is rather the routine of the individual superimposed upon a none too stable nervous mechanism that produces the condition "Irritable Bowel," and the condition once established works in a vicious circle. When neither a good meal and a good bowel evacuation are possible, are we not apt to become mentally disturbed?

Colon irritability is more frequent in women than men, possibly also because of the diet fads and slim figures, which lower their physical and mental stability. Incorrect food not only in kind, but bulk, alcohol and tobacco, are also contributing factors. Coupled with that mentioned above is the vicious habit of laxative or enema taking by lazy people or busy people, and lazy bowels. People of middle adult life seem most affected, although a similar condition is reported in children and early adult life. Food allergies, as reported by Eusterman and Hollander[6], may also be a factor. Other intra-abdominal conditions, of course, may cause a colon malfunction.

SYMPTOMATOLOGY

The symptoms of irritable bowel are quite classical. There is usually a complaint of distress, coming on fifteen minutes to an hour after meals, and described as a sense of fullness or weight in the abdomen in the region of the umbilicus. An associated languor and lack of "pep," is common to many. Belching with temporary or partial relief, nausea and sometimes vomiting may follow food taking. Rumbling and gurgling in the abdomen between meals, and if the irritability is sufficient, pain, cramplike in character, may also be present. The pain is intermittent and is usually confined to the lower abdomen, although Jordan and Kiefer[7] reported 58 cases out of 80, with epigastric distress of the ulcer type and frequency. Relief from distress with bowel evacuation or enema is common. Heartburn is a frequent complaint, often associated with gaseous eructations. Constipation with the passage of marble or pencil stools occurs, but also frequently the stool is soft with several daily. Mucous stools are not common in this stage of the upset.

The physical findings relative to the abdomen are quite typical. Palpation of the colon usually reveals a tender contracted descending colon, which when rolled under the fingers many times duplicates the patient's distress. At times the tenderness may be confined only to the caecum and ascending colon, which may be contracted or redundant, and the gurgling contents expressed. It is this type that frequently

comes to operation for chronic appendicitis. Jordan and Kiefer[7] report 26% of two hundred cases of irritable bowel, in whom the appendix had been removed, and I believe while with the late B. W. Sippy our percentage was about the same.

The Ewald test meal, in my experience, frequently shows either a hyperacidity or the high extreme of normal, when free acid is present.

The colon, filled with barium enema on fluoroscopy, may appear contracted, filling rapidly with a smooth outline in the pelvic and descending portions, haustral markings being evident only in the transverse and ascending portions and the caecum atonic, or a normally appearing colon may be seen which intermittently contracts and relaxes with distress to the patient. This is seen particularly over the descending portion of the colon. Light palpation frequently produces this spasm.

The treatment of irritable bowel may be best suited to hospitalization, particularly if the distress is quite severe or long standing, or if the individual is a particularly neurotic type. If the patient is sufficiently intelligent to co-operate with the physician and his confidence gained, he can be treated as well at home, or even at the office. As emphasized by Alvarez[8], a correct diagnosis is necessary, but also an understanding of the patient's social life is essential. Many of these cases experience constipation either actual or supposed, and take either laxatives, purgatives or large enemas. I find that a great deal is gained by explaining to them why they are constipated and why they should not take laxatives and large soap enemas. When they understand that a definite period is necessary before food eaten can leave the rectum as feces and that if the lower descending colon and rectum is emptied either by laxatives or large enemas that they are likely to have no stool or fecaliths the next day, fear of constipation is removed. Also the patient is given an insight into "his workings." Diet corrections also are made, a bulk or soft diet being given depending on the type of distress, degree of distress and character of the stools. With decrease of distress and improved appetite the mental state of the patient also improves. They are then advised about over-stepping their diet, avoiding worry and strain, over fatigue and taking cold, or chilling of the body. If ambulatory, I suggest heat to the abdomen in the evening. If in bed, either a hot water bottle, or pad or heat lamp, at alternate hours.

The drug therapy usually includes some form of belladonna and possibly some combination of alkali and bismuth.

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ESSAY CONTEST ON GOITER

The American Association for the study of Goiter again offers an award of three hunderd dollars ($300.00) for the best essay based upon original research work on any phase of goiter presented at their annual meeting in Kansas City, Mo., April 7th, 8th and 9th, 1931. It is hoped this offer will stimulate valuable research work, especially in regard to the basic cause of goiter.

Competing manuscripts must be in the hands of the Corresponding Secretary, J. R. Yung, M. D., Terre Haute, not later than April 1, 1931.

Ultra-Violet and Heliotherapy in Tuberculosis*

By R. D. THOMPSON, M. D.
Superintendent Wisconsin State Sanatorium,
Statesan

The subject of the use of ultra-violet and heliotherapy in tuberculosis is a most interesting and timely topic today.

We cannot but commend the lay people on the way they are using it in early childhood and the later years of growth. With the large number of children, young men, and women wearing sun and bathing suits for hours at a time we certainly have reason to feel that in years to come we should have healthier and sturdier people taking our places.

However, there is much to be said relative to the abuse of this form of therapy which the laity has accepted for many types of disease, using it without one bit of advice from their family physician, without any idea of what the results may be. They have used it indiscriminately as the one great free remedy for many ills and aches, and, truly, too many have heralded it as the greatest factor in the cure of tuberculosis regardless of its form or of what organs of the body may be involved.

Not only is the laity using this splendid type of therapy injudiciously, but there are many so-called nature doctors, electric specialists, chiropractors, and many others who have definitely abused this creditable type of treatment and are still doing so. Then why should we not find many people going about with pigmented skins produced both by artificial and real sunlight, they having been treated for every ailment that most any doctor ever heard of and not being mindful of the fact that heliotherapy has a definite place in the treatment of certain infections but is not a cure-all or a specific remedy for any one disease.

There are also a few physicians who, I believe, are using artificial sunlight therapy without definite knowledge of what the result might be, what dosage the different patients can stand, and what degree of erythema or reaction should or should not be obtained. During a conversation last spring with a very well known roentgenologist he said, "Doctor, I have never in my life x-rayed so many patients for gastric ulcer and gallbladder disease who were so well tanned up from chin to symphysis and who had not been south for the winter."

Truly, heliotherapy holds a very definite place, and always will, in the therapy of tuberculosis. Direct sunlight and also ultra-violet rays given in large doses are powerful agencies. That as a therapeutic instrument it is powerful for good is now widely known, but that it is equally, or even in a greater degree, powerful for harm is not, there is reason to believe, so generally understood. In writing this paper it is my chief purpose to emphasize the grave dangers involved in heliotherapy as it is applied to tuberculosis, especially pulmonary, and to urge that it be prescribed and administered with the utmost caution.

The idea that sunlight will cure tuberculosis has been popularly accepted and, too, it has become immensely attractive. So popular has it become that it is not surprising that when a man learns that he is suffering from this infection he immediately begins to bare himself to the sun. Many are doing it today without the physician's advice, with no knowledge as to whether it is indicated in the particular case or as to how, were it indicated, it should be gone about, and many individuals having pulmonary tuberculosis have really put themselves beyond the hope of a cure. For this state of things we have no direct responsibility, though to me it appears incumbent upon us to use every means to remove the current misconceptions that bring it about.

Too few physicians realize that each new patient for whom heliotherapy is prescribed offers a new therapeutic problem, for everything depends upon the reaction of the patient, for in nothing do people differ more, and sometimes in a very perplexing manner. We know that in some types of tuberculosis sunlight is useful and in others it is useless or far worse than useless.

* Presented before the 89th Anniversary Meeting, State Medical Society of Wisconsin, Sept., 1930.

INDICATED TYPE

Sunlight therapy is indicated in certain types of tuberculous infection; it must be administered with patience and skill, and with correct technic. I shall classify tuberculosis into two classes, namely, extra-pulmonary and pulmonary. The first class includes the infection of the skin (usually lupus), external lymph glands, bones, joints, and so forth. In all of those lesions sunlight therapy is indicated provided there is no pulmonary involvement, and along with heliotherapy we must have hygienic treatment with rest, both mental and physical, fresh air, and nutritious food. Patients in this class who may have an associated pulmonary lesion may receive exposures, but great care should be taken to avoid reactions, and especial care exercised in exposing the chest, and as a general rule it is better not to expose the chest to the direct rays.

In the pulmonary types of tuberculosis we have definite classifications, one the childhood type, the other the adult or definite lung type. The former consists of an infection of the tracheo-bronchial glands, due to childhood infection, and in this type heliotherapy is truly indicated.

WHEN NOT INDICATED

In the true pulmonary or adult type of tuberculosis, which represents eighty-five per cent of all forms of this infection, we have a different picture. We have here two definite types, a productive or fibroid type and an exudative or ulcerative type. It is in these two forms, especially the latter, that heliotherapy does serious and frequently fatal harm. The distinction between productive and exudative tuberculosis is not a hard and fast one, nor is it a constant one, because an infection which we at first put in one class we may, at a latter date, place in the other. There is no rigid wall between these two forms but they are as a rule easily differentiated in practice.

The exudative type is commonly marked by a more sudden onset, not insidious when we think of tuberculosis as a chronic infection. It produces high temperature, rapid pulse, decided loss of weight, cough, expectoration, and frequently night sweats. On physical examination it often shows only a small area of involvement in spite of the pronounced constitutional symptoms, but at the same time an activity within the restricted area that is destructive and intense. The x-ray film reveals definite mottling, either fine or coarse, without much peribronchial increase and with a marked tendency, as the disease progresses, toward cavitation and a coalescing of contiguous small cavities.

The productive or fibroid type is marked by its deliberateness and insidiousness. It develops more or less imperceptibly and produces few or mild toxic symptoms, with little cough and expectoration, and infrequent night sweats. Physical examination reveals a large area of involvement, slight activity, many fine moist rales, with but little extension and breaking down. The roentgen ray defines peribronchial strands or formations which are commonly diffuse and seldom accompanied by cavitation.

The use of heliotherapy in the exudative or ulcerative type is never indicated, and I am sorry to say that it is in this form that usually all types of treatment are still used. In the productive type we do find heliotherapy indicated in a certain few cases, especially the case that reaches normal weight, has little cough or expectoration, no constitutional symptoms, but still moist rales and a positive sputum, the case, if you will, that seems to be at a standstill. Here we may use heliotherapy, but with extreme caution, with skill and patience, and without increased physical exercise, as there are, I feel, too many of this type that are obliged to walk or be transported to physician's office for the light treatments, the good results of which are counteracted by the exercise.

I recall many patients during my few years of sanatorium work who were so happy to enter a sanatorium and had pinned so much faith on the sanatorium as a "Haven of Cure" who were much surprised that we did not give them some form of light treatment such as they had previously had, and whose names later appeared on the stub of the death certificate.

Only recently I was in conversation with a medical man who wanted to know what he

should do with a young male patient twenty years of age, who refused to go to a sanatorium and had turned himself loose on a farm wearing only shorts and tennis shoes and was having hemoptyses every three or four weeks. This young man, of course, if not already an exudative type was fast becoming one, and his life will naturally last only six to twelve months longer.

A large percentage of the patients suffering from some extra-pulmonary form of tuberculosis come to the attention of specialists, especially the orthopedist and dermatologist, but it is the pulmonary types, namely the childhood and adult forms, that are first seen by the man doing general work. He is the one who is first called upon to direct the destinies of such cases. The childhood type with the enlarged tracheo-bronchial glands does very well under heliotherapy and each case should receive that treatment. In the adult type the differentiation between the productive and exudative forms must be made, and if heliotherapy is indicated it must be given very cautiously.

At the Finsen Light Institute, in Denmark, where a large part of our knowledge of light therapy has originated, they are using such therapy in all cases of adult types, but the time of exposure is only from thirty to forty seconds, given only three times a week. They know that these small doses are stimulating and are entirely free from reactions.

I hope that I have given to you what we, who are doing work in tuberculosis, have learned from our experience and are practicing today.

SECTION ON RADIOLOGY

H. B. PODLASKY, M. D., Editor

Roentgenologic Manifestations of the More Common Inflammatory Diseases of the Lungs*

By B. R. KIRKLIN, M. D.
Section on Roentgenology
The Mayo Clinic, Rochester, Minnesota

For more than three decades the roentgen ray has been employed as an aid in the diagnosis of intrathoracic diseases, but despite its ready availability and the valuable assistance which it renders, too often it is neglected or is called into service only as a last resort and after a delay, at the patient's risk. Roentgenologic examination is not a rival of clinical study, but is an extraordinarily useful adjunct to the latter, and roentgenologic data must be interpreted with a prudent regard for clinical facts and common sense. The technic need not be discussed here, and it will be sufficient to say that although roentgenoscopy often is desirable as a supplementary procedure, films, preferably stereoscopic, are the mainstay of diagnosis.

Among pulmonary inflammations, tuberculosis is particularly needful of early and accurate diagnosis. As a rule, the truly early cases will be discovered only by roentgenography of the thorax, applied as a routine, regardless of the patient's chief complaint, for when pulmonary symptoms have become sufficient to attract attention, the disease usually will be rather far advanced. Virtually all incipient cases in adults are included in two groups. In the first group, which comprises by far the greater number, the earliest visible manifestation is a region of slight opacity in an upper lobe, more often of the right lung, and, as pointed out long ago by Wessler, and later by Assmann, not in the supraclavicular apex, but just below the clavicle and in the parenchymatous portion of the lung. The affected region is more or less triangular or conical; its base is at the periphery of the lung, its apex is

* Read before the Radiological Section of the Wisconsin State Medical Society, Green Bay, Wisconsin, May 23, 1930.

directed toward the hilum, and it usually lies at the level of the first interspace, occasionally, the second. The shadow is made up of a network of delicate lines enveloped in a filmy veil; it has been likened aptly to a web spun by a caterpillar about an outer branch of a tree. In the second group, the lesions are likewise situated in the subclavicular region but are roughly spherical in form, usually multiple, sometimes single. They are of faint density; their size varies from a diameter of a few millimeters to that of several centimeters, and multiple lesions are of diverse sizes.

In most cases of either group, the shadow of the bronchovascular trunk, leading from the diseased region to the hilum, is intensified. It should be emphasized, however, that intensified vascular markings, without shadows in the parenchyma, are by no means sufficient for the diagnosis of tuberculosis. At one time, exaggeration of bronchovascular markings, with so-called "beading," was deemed sufficient warrant for the diagnosis of peribronchial tuberculosis. It has been found that patients in whom such markings are seen are often in robust health and that in them frank tuberculosis almost never develops. "Peribronchial thickening" is also a phrase which should be used circumspectly, or not at all, in this connection.

Extremely limited, simple inflammatory or thrombotic processes, or localized partial atelectasis, or the residua of an acute infection, or bronchiectasis of slight degree without drainage, restricted to the infraclavicular region, may resemble the irregularly conical web produced by early tuberculosis. Likewise, malignant metastatic nodules at an early stage may imitate early tuberculous nodules. Practically, however, such simulation is rare, and lesions of the sort described warrant a tentative diagnosis of tuberculosis. Small, ancient, healed tuberculous lesions, which frequently are found in adults, scarcely will be confused with those which are early and active. Healed foci are relatively dense and have sharp margins; early and active lesions cast faint shadows, with hazy, ill-defined edges.

Advanced tuberculosis in adults is characterized by the multiplicity of its pathologic components, which consist in varying proportions of simple or conglomerate tubercles, gross nodules, caseous pneumonia, fibrosis, calcification, cavities, bronchial dilatation, local atelectasis or compensatory emphysema, contraction of the lung, pleural thickening, adhesions, and pleural effusion. Obviously, therefore, the picture varies. Nevertheless, the shadows have major characteristics which are almost pathognomonic. The shadows are more or less heterogeneous, situated almost invariably in the regions of the upper lobes, and most pronounced in the subclavicular and apical regions. The disease tends to progress from above downward; hence the older and denser lesions are above, and the newer lesions, with their fainter shadows, are in the advancing margin below. When the condition is bilateral, involvement of the two sides is almost invariably markedly unequal.

The differential diagnosis is seldom difficult unless one or another element, such as fibrosis or caseous pneumonia, dominates the picture, in which event the disease may be confounded with pneumonoconiosis or pneumonia.

Primary, or focal, tuberculosis, which occurs most often in children, differs in many respects from the common types found in adults. Although it affects upper lobes as a rule, it tends to involve circumhilar regions and lower lobes more often than it does in adults. The lesion is usually a caseous bronchopneumonia; fibrosis is scanty or lacking and the association of old and new lesions is far less common than in adults. Moreover, the tracheal, bronchial, and pulmonary lymph nodes are enlarged, whereas in adults the nodes are not enlarged but at most only calcified. The condition should be distinguished chiefly from simple bronchopneumonia, which produces a similar mottled shadow.

MILIARY TUBERCULOSIS

For the revelation and diagnosis, with confidence, of miliary tuberculosis, which occurs both in children and adults, almost sole reliance must be placed on the roentgen ray examination. The pulmonary fields have a finely granular appearance and the tuber-

cles are seen as countless, small, faint shadows distributed throughout the lungs rather evenly, or perhaps apparently somewhat grouped in the upper lobes. Although the shadows are usually uniform in size, those in the upper portions of the lung are sometimes appreciably larger. Chiefly to be considered in the differential diagnosis are miliary metastasis, in which the nodules are irregular in size and most numerous in the lower two-thirds of the lung, and mild forms of pneumonoconiosis, in which the nodules are usually coarse, rather dense, irregular in size, and more marked in the circumhilar portions of the lung. Rarely the shadows are small, evenly distributed, and closely resemble those of miliary tubercles.

In lobar pneumonia, with its usually definite and pathognomonic clinical signs, the roentgen ray is less essential for diagnosis than for the demonstration of the exact seat and extent of invasion and the advent of pleural effusions and other complications. In the stage of engorgement, the roentgenologic signs are not pronounced, but the hilar shadow is likely to be enlarged, and the vascular markings are likely to be intensified. Shortly, a delicate, more or less uniform, veil-like shadow appears over the affected lobe. When the stage of hepatization is reached, the density of the shadow is increased but is not commonly sufficient to obliterate the ribs; it is usually homogeneous but may have thin areas. Some part of its margin is likely to be sharply marked and to coincide with the lobar border. In the stage of resolution, the shadow becomes lighter and mottled, with relatively clear areas; its appearance has been compared to that of a thin piece of melting ice. Delayed resolution and complications, such as pleural effusion, empyema, and abscess, are of course readily demonstrable with the roentgen ray. Distinction from other diseases is not usually difficult, although caseous tuberculous pneumonia or bronchopneumonia sometimes imitate the croupous form.

Bronchopneumonia is usually found in the posterior portions of the lower lobes. Seldom are the upper lobes affected, and the right middle lobe is said to be almost exempt. The shadows, which are scattered along the bronchovascular markings and in the parenchymal fields, vary as to size, configuration, and density, and they have hazy margins. Exclusion of simulants, such as congestion and edema, may require careful analysis of the roentgenologic picture in the light of the clinical facts. An early and persistent sign of bronchopneumonia, not seen in congestion or edema, is elevation, or so-called splinting, of the diaphragm on the affected side.

Nontuberculous abscess results most often from pneumonia, or aspiration of foreign bodies or infectious material, especially during tonsillectomy. Abscesses vary in size up to 10 cm. or more in diameter, and their site of election is the more central portion of the lung, especially of the lower lobes. They are likely to be roughly spherical or ovoid in form, but may be irregularly shaped. In the early stage the shadow of an abscess is rather homogeneous, but when softening begins, it becomes mottled. If the abscess discharges into a bronchus, the cavity may be seen to be partly filled with fluid, above the level of which a transradiant air-bubble appears.

Bronchiectasis is commonly a result of bronchostenosis ensuing on any of the various inflammatory diseases of the lung or the aspiration of a foreign body. It is relatively common, is frequently mistaken for tuberculosis or other disease, and to diagnose it confidently almost requires the use of the roentgen ray. The dilatations may occur in the principal bronchi of any lobe, but are found most often in those of the lower lobes. In early cases there may be little more than accentuation of the hilar and bronchovascular markings. With further progress, and in classic instances, the areas of dilatation, when empty, appear as grouped, cylindrical, fusiform or saccular transradiant areas in the course of the larger bronchi. When filled with secretion they produce dense shadows, which may resemble a bunch of grapes. Distinction from abscess, bronchial carcinoma, or other diseases may be required. Bronchography, after the introduction of lipiodol into the bronchi, is help-

ful in demonstrating bronchiectasis, especially when the areas of dilatation are situated behind the heart.

There are many rarer diseases, in the diagnosis of which the roentgen ray gives outstanding assistance, and its aid should be demanded more often than it is now. Indeed, it is not impractical to hope that roentgenologic examination of the thorax of every patient will be made a routine.

THE JOURNAL CLINIC

Congenital Solitary Kidney; Ptosis Causing Acute Hydronephrosis*

By GEORGE H. EWELL, M. D.
Jackson Clinic, Madison

Congenital solitary kidney is comparatively rare. According to Beer and Hyman in a series of 136,766 autopsies, the absence of one kidney was noted 180 times or 0.8 per cent. The majority of cases reported are from autopsy reports or from reports of the unfortunate deaths which have occurred from operations on or the removal of these solitary kidneys.

With the advent of modern diagnostic methods in urology, the occurrence of this anomaly is not as rare as formerly thought and combined autopsy and clinical studies show its presence, according to Beer and Hyman, approximately once in 1250 cases.

While we appreciate the fact that it is almost impossible to differentiate between unilateral solitary kidney and advanced degrees of hypoplasia with a closed off, rudimentary ureter, we feel that we are justified in making a diagnosis of solitary kidney in our case after having failed by all methods of careful examinations to demonstrate the existence of another kidney.

Congenital absence of one kidney has long been known and the literature contains many references to cases proved at autopsy. Fortune compiled 422 such cases in 1927 and Carson compiled 446 cases in 1930.

A study of statistics shows that the agenesis occurs more often on the left than the right side and that the solitary kidney may be normal in size, hyperplastic, hypoplastic or hypertrophied. Anomalies in the vascular supply occur as demonstrated at operation in our case.

Beer and Hyman have demonstrated congenital absence of a kidney eight times in adults and once in a child, the absence of pathologic changes to produce symptoms probably accounts for its infrequent demonstration in children. Congenital defects in the genital tract of both sexes are frequently associated with agenesia of the kidney. In males the most common is the absence of vas, ejaculatory duct or seminal vesicle on the affected side and rarely absence of the epididymis or testicle. In the females the defects usually found are uterus bifidus and unicornus with absence of the tubes, uterus or vagina. Absence of an ovary seldom occurs. In our case the absence of the uterus, tubes and vagina was proved at physical examination and laparotomy.

Embryology: The metanephron or permanent kidney is preceded by the pronephron and the mesonephron or wolffian body. While the metanephron is developing and becoming a functioning organ, the mesonephron is undergoing degeneration. A few of its remnants persist into the formation of the genital apparatus.

Johnson says that true agenesia is due to a failure of the ureteral bud to develop; the ureteral bud has its origin on the dorsal surface of the wolffian duct close to the point where the wolffian duct enters the cloaca.

DIAGNOSIS AND CLINICAL IMPORTANCE

The clinical diagnosis of solitary kidney is extremely difficult; there are no characteristic symptoms or signs. Careful urologic

* Presented before North Central Branch, American Urological Association, Indianapolis, Oct. 23, 1930.

Fig. 1. Pyelogram with patient in horizontal position on a Foley table.

Fig. II. Pyelogram with patient in vertical position on a Foley table showing a marked ptosis.

study is required, roentgen-ray examination may reveal the absence of the kidney shadow; this finding cannot be entirely relied on as crossed dystopia with fusion may present the same findings. The use of uroselectan intravenously is of great value in the suspected cases.

Careful cystoscopic examination is important. Variations in the trigon may be present or it may be normal. The urethra and vagina should be carefully examined for the presence of an ectopic ureteral orifice. The intravenous injection of indigo carmine is of great assistance. The ureter should be occluded with a large catheter, injections of indigo carmine given repeatedly, and the bladder, urethra and vagina carefully searched for a second ureteral opening.

Fortune found ten cases reported following nephrectomy of a solitary kidney. Winter collected seven cases, and in the Eppendorfer Krankenhaus in Hamburg, six deaths followed the removal of solitary kidneys; these deaths occurred before cystoscopic examination was established as a routine measure.

It does not seem necessary, therefore, to emphasize the importance of this subject in the light of our present means of examination, yet within the past two years, one surgeon reported before one of the large societies that he was forced to do a plastic operation of doubtful outcome on a kidney pelvis and ureter following the removal of a stone, because he could not do a nephrectomy as he did not know the condition of the other kidney,—assuming that one did exist.

CASE REPORT

A nurse, aged 33, came to the Jackson Clinic June 27, 1930. Her family history was irrelevant. Past history—typhoid (?) at eight. Menstruation had never occurred. Between 13 and 15 years of age she had frequent nose bleeds, but never noticed that they occurred at regular intervals. In 1916 a laparotomy revealed the absence of the uterus, tubes and vagina; both ovaries were present. There has been frequency and dysuria as long as she can remember. In 1922 while lifting a patient she was seized with a severe pain in the left upper abdominal quadrant and back followed by chills and fever. Cystoscopy the following day gave immediate relief from pain, pyelography caused its return, requiring an inlying ureteral catheter for twenty-four hours for relief. A heavy feeling remained from eight to ten days.

Fig. III. Pyelogram ten weeks following nephropexy with patient in vertical position on a Foley table, showing kidney in normal position.

During the succeeding four years, a heavy full feeling occurred about twice a year in the left upper abdomen, bed rest for a few days would give relief. In 1926 severe dysuria was present for four days followed by acute pain in the upper left quadrant and the left renal region, chills and fever. Cystoscopic examination two days later gave no relief, cystoscopy forty-eight hours later relieved the pain with subsidence of temperature.

June 27, 1930, following exertion from lifting, a heavy feeling again occurred in the left upper quadrant followed in a few days by a sudden attack of acute pain. Cystoscopy twenty-four hours later, with aspiration of 25 cc. urine from the renal pelvis, relieved the severe pain although the heavy feeling persisted. Forty-eight hours later acute severe pain with chills and fever occurred. Cystoscopy, aspiration and lavage afforded relief but the heavy feeling persisted. One week later the preceding symptoms returned and were relieved by cystoscopy, the heavy feeling persisted until operation August 6, 1930.

Physical examination June 27, 1930, was negative except for a large tender left kidney which was freely movable and descended about 2 inches when standing erect, absence of the vagina was noted and on rectal examination no evidence of a uterus could be made out. Extremities were negative.

Laboratory examinations: Catheterized bladder specimen pus 1, red blood cells few, routine blood examination normal, left kidney specimen pus few, cultures on three separate occasions were negative. Cystoscopic examination showed the trigon to be very short and its margins rather indefinite especially so on the right. The left ureteral orifice was normal in appearance; there was diffuse cystitis grade 1. Indigo carmine appeared from the left ureter in four minutes, concentration was good. Several cystoscopic examinations with repeated injections of indigo carmine failed to reveal a right ureteral orifice. Roentgen-ray examinations revealed no evidence of a kidney silhouette on the right. With intravenous uroselectan the left kidney pelvis and ureter were visualized but no evidence of a right kidney was demonstrable. The pyelogram with the patient in the horizontal position is considered normal and with the patient in the vertical position the kidney descends about two inches, as shown in the accompanying photographs Figures 1 and 2. A diagnosis was made of a left solitary kidney, left nephroptosis, chronic left pyelonephritis and chronic cystitis.

Nephropexy was performed August 6, 1930, by Drs. R. H. Jackson and G. H. Ewell after the method described by Deming. The kidney was very large, and fetal lobulations were quite distinct. Three arteries arising from the aorta and three veins emptying into the vena cava were demonstrated as shown in Figure 4. The lowermost vessels passed behind the ureter and in front of the pelvis to enter the kidney parenchyma. These vessels were considered as the partial cause of obstruction at the uretero-pelvic junction, and on ac-

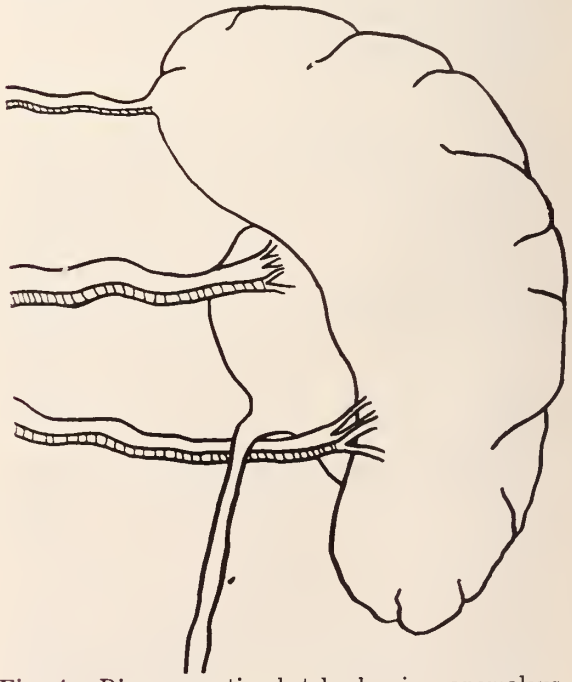

Fig. 4. Diagrammatic sketch showing anomalous blood supply.

count of their size they could not be ligated and severed.

Since the operation the patient has gained eight pounds, the heavy full feeling in the left upper quadrant has disappeared and her health is greatly improved. A pyelogram with the patient in the vertical position ten weeks after the operation shows the kidney to be fixed in its normal position. (Figure 3.)

CONCLUSIONS

A congenital solitary kidney is not as rare as formerly believed. It is possible by our present diagnostic methods to establish its existence for practical purposes. No surgical procedure should be undertaken on a kidney unless the existence of its mate is demonstrated and its function is sufficient to sustain life.

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Prenatal Care

The United States Children's Bureau publication, "Prenatal Care," has recently been revised and was issued in a new edition in December. The letter of transmissal states that the revision is the work of Dr. Robert L. De Normandie, in cooperation with the members of an advisory committee of obstetricians and with Dr. Blanche M. Haines, director of the maternity and infant hygiene division of the Children's Bureau. The members of the committee are: Dr. Robert L. De Normandie, Harvard Medical School, chairman; Dr. Fred L. Adair, University of Chicago; Dr. Rudolph W. Holmes, Northwestern University Medical School, Chicago; Dr. Ralph W. Lobenstine, New York; Dr. Frank W. Lynch, University of California Medical School; Dr. James R. McCord, Emory University School of Medicine, Atlanta; Dr. C. Jeff Miller, Tulane University of Louisiana, New Orleans; Dr. Otto H. Schwarz, Washington University School of Medicine, St. Louis; Dr. Alice N. Pickett, University of Louisville School of Medicine, Louisville.

Forty-four per cent of the Wisconsin mothers who died in childbearing during the years 1927 and 1928 had no prenatal care, according to the study made by the State Board of Health in cooperation with the State Medical Society. In 44% of the deaths the patient had not been seen by a physician prior to the delivery or to the development of the fatal condition.

In a program of urging the need of adequate prenatal care and of medical supervision during pregnancy and at delivery, the Bureau of Child Welfare sends a series of letters, one each month, to expectant mothers for whom they are requested by the physician, nurse, or by the mother herself. The Children's Bureau publication, "Prenatal Care," is sent with the first letter. During the past two years 204 physicians of the state have requested the letters and this publication for their patients.

A copy of the new edition of the pamphlet and a sample set of the letters have been sent by the Bureau of Child Welfare to every physician of the state who is recorded as attending obstetrical cases. Requests for the letters and literature for prenatal patients may be addressed directly to the bureau, where the mailing list remains a confidential record. The letters are sent in a plain envelope, bearing only the return address of the Board of Health. Physicians wishing to use the prenatal letter service for their patients may obtain from the Bureau printed slips for their convenience in referring requests.

GOVERNOR APPOINTS

As this Journal goes to press, Governor La Follette announces the re-appointment of Dr. Mina B. Glasier of Bloomington as a member of the State Board of Health for the term ending February 1, 1938. Dr. J. W. Lambert, Antigo, was appointed the state's delegate to the Conference on Hospitals and Medical Education to be held in Chicago in February.

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EDITORIALS

IMPORTANT TO YOU

ELSEWHERE in this issue we publish, in much detail, the proceedings of the January meeting of the Council of the State Medical Society. As observers of innumerable Council meetings of the past, we are perhaps qualified to emphasize the amount of business and its importance transacted at this all-day session.

Every member-reader should be acquainted with the aims and policies of the Society; with the details of its budget and the transactions of its Council. This will all be found in this issue and we commend it to you for careful reading.

GROUP ADVERTISING

FROM time to time there comes to the profession proposals that group advertising will solve the economic ills to which the medical profession seems to be heir. On this general subject we presented our conclusions editorially, April, 1930, declaring our belief that advertising would solve none of our problems and would ill serve the public.

More recently, however, it was proposed to members of the Dane County Medical Society that they finance a program of insertion of twenty-six, full page, syndicated advertisements which had as its desideratum educating the public to a greater appreciation of the services of the profession with the thought that they should pay their doctors "first." Wisely, we believe, the Dane County Society voted unanimously, after a full and frank discussion, not to approve such an advertising campaign.

The problems of the physician are many. How he may secure a fair income that will provide an education for his children, grant him some measure of comfort and a degree of security for old age is one common to all. Its solution by a physician, however, varies from the usual.

His success in life depends not upon "drummers" but upon the excellence of his talents in bringing relief to the sick at a cost that is reasonable for each, regardless of station in life. The physician maintains no credit bureau upon which he decides whether the patient is a good "risk" as an installment purchaser of health. So long as he is a good physician, be he in country or city, his first concern is with his adversary—death. Being human, the physician wants to get ahead financially. We know of no great physician (and there are many, many such in our state today) who has made money his only standard of values.

At this particular time of economic stress among the laboring classes, when the profession of Wisconsin should be the first to extend charity by free treatment or extension of time for payment and is so doing,—we would bring proper condemnation upon ourselves by asking our patients to please pay us first,—cash in advance preferable. Even if we were concerned only with cash

in our pockets, this particular scheme would serve us ill.

We will never be more perfect than other human beings. We have our commendable points. We have our lamentable failings. As an organization our State Society is properly primarily interested in securing the highest type of service for the people of the state. It is properly interested in securing for the physician such financial position as is eminently just and as will attract to a great profession those who have the greatest capabilities. And we believe that the officers of the Society are far-sighted when they say that in perfections of our services lies our proper pecuniary reward.

It is always possible that in adherence to convictions based upon sound experience in such instances, the profession unwillingly may give offense to some of the press which might even lead to editorial attacks. This would be unfortunate. But we have not personalities but principles at stake. Those principles were formulated not by sumptuary edict but by experience,—not to favor the profession but to insure for the public the spirit that must actuate professional conduct. When such are the issues we must have the courage of our convictions if we are not to betray those who repose their confidence in us.

WARNINGS

"WARNINGS" to the medical profession, published in medical and pseudo-medical journals, in monthly and weekly periodicals, are becoming so frequent as to be almost bromidic (?).

In President's addresses before many medical societies; on the programs of hospital, health, insurance and educational meetings; in certain reports of the "Committees on the Cost of Medical Care" the admonitions are reiterated.

Recently President Glenn Frank repeated his remarks upon the Medical Revolution before the American College of Surgeons.

Certain "Funds" and "Foundations" appear to be interested in the future of the medical profession.

Mr. R. G. Knutsen of the Wisconsin Industrial Commission calls attention to the fact

NOTICE TO DOCTORS

New York—(AP)—Dr. Shirley W. Wynne, New York City health commissioner, was on record today with the assertion that the medical profession must give public qualified treatment at reasonable prices or face the possibility of state regulation.

He told a conference of public health and nursing service board members from six states last night that the medical profession must purge itself of members who are "as bad as any of the quacks and charletans outside" if it is to retain public confidence. He charged that the great mass of the "white-collared" class receive "poor medical service at an exorbitant cost."

"The solution of the problem lies either with the doctors organizing among themselves to supply qualified service at a fixed fee, or a public demand for state medicine," said Dr. Wynne. "Our people need and want efficient medical assistance at prices within their means, and they do not always get it."

that "discrepancies in estimation of disabilities between physicians employed by insurance companies, and those employed by the patients have the ultimate result of sowing distrust in the medical profession as a whole."

Recently, Dr. Hugh Cabot in short but forceful remarks discussed "Where do we go from here?" in a manner that arrests attention.

These we have gradually become accustomed to, but when similar, or dissimilar warnings are given bold-faced, front page publicity in the daily newspapers they perhaps call for a little different kind of attention.

On November 12, 1930, there appeared on the front page of the local press a "Notice to Doctors" which consisted of alleged quotations from an address by Dr. Shirley W. Wynne, New York City Health Commissioner, at a Public Health and Nursing Conference. Dr. Wynne is quoted as saying, "The medical profession must give public qualified treatment, at reasonable prices, or face the possibility of state regulation."

Disregarding, at this time, the question of price (reasonable or otherwise) also disregarding the possibility of state regulation (which may or may not be a wise provision) we may direct our attention to the "Quali-

fied Treatment" that the profession must give the public.

This prompts the query, what is qualified treatment?

Who judges as to the quality of the treatment?

Does relief of symptoms constitute qualified treatment?

Does death of the patient constitute unqualified treatment

If not mortality, can morbidity be used as a criterion, does the presence or absence of post operative or post therapeutic morbidity serve as an indicator to differentiate qualified from unqualified treatment? Hardly.

The comparing of a qualified with a non-qualified treatment calls for an *accurate diagnosis.* Who is to make such a diagnosis? After the diagnosis is correctly determined, a *proper prognosis* is necessary, in order to eliminate (1) those in which treatment is unnecessary as the disease is self limited and leads to a spontaneous recovery and (2) those in which a fatal termination is reasonably certain and treatment therefore cannot result in recovery.

After these essential preliminaries of correct diagnosis and proper prognosis are established, then, and then only, may treatment be given adequate study and divided into qualified and non-qualified.

The matter of fees, of state regulation, and of a multitude of other things pertaining to the practice of medicine may, in fact must, await a settlement of the above preliminaries, if any reliable conclusions are to be drawn from their discussion.

Dr. Wynne is further quoted as saying, "The medical profession must purge itself of members who are 'as bad as any of the quacks and charlatans outside' if it is to retain public confidence."

How are we to find out whether a member indulges in unethical or irregular practices?

Does he accept credit for cure in cases of self limited disease?

Does he attempt to cure incurable diseases?

Does he exaggerate the seriousness of symptoms?

Does he make unnecessary calls, treatments or operations?

Does he minimize symptoms and not recognize disease?

Does he guarantee a cure?

Does he overcharge, undercharge, or divide charges?

Does he advertise, directly or indirectly (even the profession is not united as to what is permissible).

The mere recital of such an incomplete list of possible irregularities suggests the difficulties involved. Granting that objectionable and undesirable members may be recognized, how is the profession to purge itself of such members? Expulsion from medical societies is difficult; is sometimes followed by legal reprisal against the society or individual members; does not prevent the ex-members from continuing practice, and consequently does not protect the public.

Revocation of license is still more difficult (as may be seen in recent attempts in Chicago). Even after revocation of license, or without license, extra legal practice continues and sometimes thrives under prosecution which is interpreted as persecution.

And finally, Dr. Wynne is quoted, "Our people need and want efficient medical assistance."

The need is accepted, but the recognized quacks, the patent medicines, the multitude of baseless cures, and to be explicit, the fact that one small company has sold 18,000 electric caps as a cure for baldness makes one question the *"want"* of efficient medical assistance on the part of the people.

And our experience with so-called "prohibition" should suggest serious considerations before an attempt be made to force this *"want"* upon the people.

Constructive criticism is always appreciated but the other type has a tendency to exaggerate, in the minds of the laity, many of our admitted shortcomings. The correction of these shortcomings, by legislation or persuasion, will probably be difficult but their prevention might reasonably be expected to follow changes (not entirely scholastic) in home training, fundamental and premedical education, aiming to improve the type of student seeking to enter medical schools.

F. G. C.

THE PRESIDENT'S PAGE

C. A. Harper

MEDICAL CARE OF THE INDIGENT

FEW phases of social welfare have been more difficult and more unsatisfactory than the proper, efficient medical care of the indigent, or those who are wholly unable to provide for medical care. Of the seventy-one counties about half are working under the county system, the other half retaining the old town, village, or city units as official agencies providing for the care of the indigent. There are therefore about 925 different official units wrestling with the problem. To these may be added almost innumerable organizations and social agencies.

An intelligent and economical solution of the problem is but little nearer than it was fifty years ago. Darkness and dissatisfaction to all parties concerned will still prevail until some official or semi-official agency of government looks the problem squarely in the face with the objective of an efficient and economical solution.

There are a number of conditions that lead to indigency. Undoubtedly the largest factor is due to disability on account of sickness. It is said that the very wealthy and the indigent now obtain the best medical attention. Grave exceptions can be taken concerning the proper medical care of the indigent under our present system. The supervision of the indigent is left largely to the lay public and through this supervision medical aid is sought. Usually, as a result of false economies, medical aid is not obtained by the layman for his charges until serious conditions are manifested and disease markedly advanced. The plight of the individual must be so manifested that the conscience of the official is hit hard before the pocketbook is loosened,—very frequently too late, simulating a third degree of terminal effort.

The indigent and near indigent of all people need early medical care and instruction in personal and home hygiene. The object is to improve his condition to make him a self-supporting individual. The medical care is not as efficient as it should be under our present policy. Medicine has always been a vital factor in historical events, discoveries, and the advance of civilization. The American Medical Association has formed a council on medical economics. Each county medical society should have a similar council. The first step should be toward satisfactorily solving the medical care of the indigent in their respective jurisdictions. The unsatisfactory care of the indigent in the past has undoubtedly been the largest and even the main factor in the present unrest on the part of public officials and lay men toward the general field of medicine. If solved sanely and intelligently the result will be adequate medical care of the indigent and the fuel for controversy on the subject of state medicine will become exhausted. The medical profession is now extending medical care largely at dictates of well-meaning lay men. The development of a plan that will be officially sound from the viewpoint of the public, satisfactory to the indigent, and humanitarian in every respect, is needed.

The county medical societies united toward a constructive procedure in cooperation with the county boards can work out a plan that will provide early, adequate care for the unfortunate, needy individual. It has been found that "to the county authorities the continual consideration of separate bills, the effort to appraise the value of services with which they are unfamiliar and the handling of frequent complaints from the medical profession, the public and the paupers, make the task an onerous one."

In some counties in Iowa certain plans have been carried out for over twenty years with very general satisfaction to all the interested parties, bringing about a much higher degree of efficiency in caring for the indigent, reasonably profitable to those entering into the program and with apparent greater economy when the efficiency of the work done is taken into consideration.

For details of some of the plans that have been worked out in other states refer to the American Medical Association bulletin Vol. 25, No. 9, December, 1930.

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

Officers, 1930

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TERM EXPIRES 1932
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TERM EXPIRES 1933
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LIST OF EXECUTIVE OFFICERS OF COUNTY MEDICAL SOCIETIES

County	President	Secretary
Ashland-Bayfield-Iron	W. J. Tucker, Ashland	J. W. Prentice, Ashland.
Barron-Washburn-Sawyer-Burnett	J. H Wallis, Rice Lake	E. R. Hering, Shell Lake.
Brown-Kewaunee	A. J. McCarey, Green Bay	E. S. Knox, Green Bay.
Calumet	N. J. Knauf, Chilton	A. F. Slaney, Hilbert.
Chippewa	F. T. McHugh, Chippewa Falls	J. A. Kelly, Chippewa Falls.
Clark	M. McGonigal, Loyal	E. L. Bradbury, Neillsville.
Columbia	A. J. Batty, Portage	H. E. Gillette, Pardeeville.
Crawford	A. J. McDowell, Soldiers Grove	C. A. Armstrong, Prairie du Chien.
Dane	F. J. Hodges, Madison	L. V. Littig, Madison.
Dodge	A. E. Bachhuber, Sr., Mayville	A. W. Hammond, Beaver Dam.
Door	John Hirschboeck, Forestville	T. C. Proctor, Sturgeon Bay.
Douglas	J. W. McGill, Superior	C. H. Christiansen, Superior.
Eau Claire and Associated Counties	E. E. Tupper, Eau Claire	P. G. Spelbring, Eau Claire.
Fond du Lac	H. A. Devine, Fond du Lac	H. R. Sharpe, Fond du Lac.
Grant	E. A. A. Dunn, Platteville	M. B. Glasier, Bloomington.
Green	W. B. Gnagi, Sr., Monroe	J. F. Mauermann, Monroe.
Green Lake-Waushara-Adams	J. M. Johnson, Ripon	A. J. Wiesender, Berlin.
Iowa	T. A. Hagerup, Dodgeville	H. M. Walker, Dodgeville.
Jefferson	Will Young, Ft. Atkinson	M. G. Peterson, Lake Mills.
Juneau	C. A. Vogel, Elroy	A. T. Gregory, Mauston.
Kenosha	W. H. Bennett, Kenosha	W. M. Lipman, Kenosha
La Crosse	W. J. Jones, La Crosse	R. L. Eagan, La Crosse.
Lafayette	R. B. Quinn, Darlington	W. B. Williams, Argyle.
Langlade	E. J. Donohue, Antigo	J. C. Wright, Antigo.
Lincoln	E. K. Morris, Merrill	W. H. Bayer, Merrill.
Manitowoc	W. G. Kemper, Manitowoc	C. H. Barnstein, Timothy.
Marathon	Joseph F. Smith, Wausau	Verne E. Eastman, Wausau.
Marinette-Florence	T. J. Redelings, Marinette	M. D. Bird, Marinette.
Milwaukee	E. L. Tharinger, Milwaukee	Theo. Wiprud, Ex. Sec'y, Milw.
Monroe	A. E. Winter, Tomah	H. H. Williams, Sparta.
Oconto	R. J. Goggins, Oconto Falls	G. W. Krahn, Oconto Falls.
Oneida-Forest-Vilas	C. D. Packard, Rhinelander	I. E. Schiek, Rhinelander.
Outagamie	C. D. Neidhold, Appleton	E. F. Mielke, Appleton.
Pierce-St. Croix	J. H. Armstrong, New Richmond	A. E. McMahon, Glenwood City.
Polk	L. O. Simenstad, Osceola	Geo. B. Larson, Frederic
Portage	C. von Neupert, Stevens Point	H. P. Benn, Stevens Point.
Price-Taylor	F. W. Mitchell, Medford	G. E. MacKinnon, Prentice.
Racine	J. F. Bennett, Burlington	Susan Jones, Racine.
Richland	Bertha Reynolds, Lone Rock	G. Benson, Richland Center.
Rock	F. A. Thayer, Beloit	H. E. Kasten, Beloit.
Sauk	A. L. Farnsworth, Baraboo	A. C. Edwards, Baraboo.
Shawano	R. C. Cantwell, Shawano	C. E. Stubenvoll, Shawano.
Sheboygan	John Hansen, Glenbeulah	A. C. Radloff, Plymouth.
Trempealeau-Jackson-Buffalo	J. W. Lowe, Merrillan	R. L. MacCornack, Whitehall.
Vernon	W. M. Trowbridge, Viroqua	Wm. H. Remer, Chaseburg.
Walworth	E. J. Fucik, Williams Bay	S. G. Meany, East Troy.
Washington-Ozaukee	N. E. Hausmann, Kewaskum	P. M. Kauth, Slinger.
Waukesha	W. B. Campbell, Waukesha	J. F. Wilkinson, Oconomowoc.
Waupaca	R. K. Irvine, Waupaca	F. J. Pfeifer, New London
Winnebago	G. V. Lynch, Oshkosh	M. C. Haines, Oshkosh.
Wood	O. N. Mortensen, Wisconsin Rapids	W. G. Sexton, Marshfield.

SOCIETY PROCEEDINGS

BROWN–KEWAUNEE

The December meeting of the Brown–Kewaunee County Medical Society was held at the Northland Hotel, Green Bay, on the 23rd. The election of officers for the coming year took place, and the following were chosen:

Dr. A. J. McCarey, president; Dr. O. A. Stiennon, vice-president; Dr. E. S. Knox, secretary-treasurer; Dr. P. R. Minahan, censor for three years; Dr. R. M. Carter, delegate; Dr. A. O. Olmsted, alternate.

The scientific program of the evening consisted of talks by Dr. J. W. Harris, professor of obstetrics and gynecology, University of Wisconsin, and Dr. R. C. Blankinship, associate professor of clinical medicine. Dr. Harris discussed some of the recent advances in clinical obstetrics and gynecology. His talk was very interesting and instructive. Dr. R. C. Blankinship spoke on "The Management of Peptic Ulcer." His talk was also very practical and incorporated some of the newer diets in the management of this very common ailment.

The application of Dr. W. T. Hagerty was presented to the Society for admission to the Brown–Kewaunee County Medical Society.

The meeting was very well attended by the physicians from Green Bay and the surrounding cities. E. S. K.

COLUMBIA

A regular business meeting of the Columbia County Medical Society was held at Portage on December 17th at which the following officers were elected:

President, Dr. A. J. Batty, Portage; vice-president, Dr. J. W. MacGregor, Portage; secretary, Dr. H. E. Gillette, Pardeeville; censor, Dr. A. J. Batty; delegate, Dr. C. W. Henney, Portage; alternate, Dr. H. E. Gillette, Pardeeville.

Mrs. H. E. Gillette, Pardeeville, was elected temporary chairman to arrange a woman's auxiliary.

It was voted that the next meeting be held in February to be followed by meetings every two months thereafter. H. E. G.

DANE

The January meeting of the Dane County Medical Society was held Thursday, January 22nd, at St. Mary's Hospital, Madison, in keeping with the new plan for 1931 of holding all scientific meetings throughout the year at the various Madison hospitals, two meetings at each of these institutions. The program presented was as follows:

"City Health Program for Diagnosis and Management of Pulmonary Tuberculosis" by Dr. F. F. Bowman, Madison.

"Incidence of Tularemia, Malaria and Undulant Fever," by Dr. H. M. Guilford, Madison.

"Value of Laboratory Methods for Diagnosis of Whooping Cough" by Dr. W. D. Stovall, Madison.

Under new business on Thursday night, the Dane County Society formally voted unanimously to deny the endorsement of the Society for a "pay your doctor" publicity campaign which had been presented to many of the members individually by a local newspaper.

The problems of the local Physicians' Exchange were discussed in detail and the matter of extending or withholding the endorsement of the Society was laid over until the next meeting, when it will become a special order of business. The scientific papers dealing with problems in the diagnosis and control of various communicable diseases was splendidly handled by Drs. Bowman, Guilford and Stovall. One very interesting case of tularemia to illustrate part of the evening's subject matter was presented by Drs. Karl Smith and M. J. J. Coluccy.

F. J. H.

GREEN LAKE–WAUSHARA–ADAMS

Dr. J. M. Johnson of Ripon was named president of the Green Lake–Waushara–Adams County Medical Society, and Mrs. Orvil O'Neal, also of Ripon, was elected president of the Women's Auxiliary of the Society, when members of the associations met at the Hotel Whiting in Berlin on December 19th for their annual meeting.

Other officers of the Society who will serve for the year are: Dr. S. L. Casper, Berlin, vice-president; Dr. A. J. Wiesender Berlin, secretary-treasurer, and Dr. C. U. Senn, Ripon, censor.

Other officers of the Auxiliary include Mrs. B. E. Scott, vice-president; Mrs. A. J. Wiesender, Berlin, secretary; Mrs. J. M. Johnson, Ripon, treasurer.

Following a dinner served at six thirty o'clock, an address was made by Dr. W. S. Middleton, of the University of Wisconsin, on the subject of "The Clinical Interpretation and Treatment of Nephritis."

LA CROSSE

The regular meeting of the La Crosse County Medical Society was held at the La Crosse Club. The meeting was called to order by the President at 8 P. M.

The minutes of the previous meeting were read and approved as read.

Letters from Dr. A. A. Maurer and Dr. J. A. Bradfield thanking the Society for electing them honorary members were read. Dr. James Evans thanked the Society in behalf of his father, Dr. E. E. Evans.

All members joined in discussing an interesting talk on "The Medical Management of Peptic Ulcer" given by Dr. Blankinship of the Wisconsin General Hospital.

The Society was glad to have Dr. A. A. Maurer, an honorary member, present at the meeting. He furnished cigars and cigarettes for the members present.

The meeting adjourned. R. L. E.

MANITOWOC

Dr. W. G. Kemper was re-elected president of the Manitowoc County Medical Society for the year at a meeting on January 2nd which followed a six o'clock dinner at the Hotel Manitowoc.

Dr. F. W. Hammond, Manitowoc, and Dr. C. H. Barnstein, Timothy, were elected vice-president and secretary-treasurer, respectively.

Dr. C. M. Gleason, Manitowoc, was elected delegate and Dr. A. J. Shimek, Manitowoc, alternate to the annual meeting. Drs. J. M. Kelley of Cato and J. E. Meany, Manitowoc, were elected censors.

A committee was appointed to draw up resolutions of sympathy dedicated to the memory of the late Dr. John L. Shaw, a copy to be spread on the records of the society and a copy to be sent to the bereaved family.

MARINETTE–FLORENCE

The Marinette–Florence County Medical Society met Thursday evening, January 22nd.

Dr. H. T. Sethney (H. T. S.) of Menominee, Michigan, read a paper on "Fractures" which caused considerable discussion and was well received.

Dr. J. V. May gave an address on "Some Affections of the Vitreous" and presented a series of slides on prevention of eye injuries.

Letters have been received from the party including Dr. and Mrs. Redelings, Dr. and Mrs. Sawbridge and Dr. Luella Axtell, reporting a wonderful trip through the Panama Canal on their way to California. M. D. B.

MILWAUKEE

The first monthly meeting of The Medical Society of Milwaukee County was held at the New County Hospital, Wauwatosa, on January 9. Prior to the meeting members of the Society, who were guests of the staff of the County Hospital, inspected the new building.

The regular meeting was called to order at 8 P.M. by President E. L. Tharinger. The Executive Secretary presented his annual report of the Society activities, which was approved.

Following the business session the scientific program was presented.

1. "Complications of Diabetes Mellitus." An analysis of 827 cases observed at the Milwaukee County General Hospital. Dr. Francis D. Murphy.
2. "Autogenous Bone Peg for the Treatment of Intracapsular Fracture of the Hip." Dr. Chester C. Schneider.
3. "Prostatectomy with Primary Closure." Dr. James C. Sargent.

This meeting proved to be one of the largest held by the Society. There were more than 250 present and much enthusiasm was in evidence over the first program of the year. The scientific program concluded promptly at 10 P.M. when the meeting adjourned, and the social hour was held. A luncheon was served in the cafeteria of the New County Hospital.

RACINE

The annual meeting of the Racine County Medical Society was held at the Racine Elks Club on Monday evening, December 18th, at eight o'clock. The following officers were elected:

President, Dr. J. F. Bennett, Burlington; vice-president, Dr. W. C. Roth, Racine; secretary-treasurer, Dr. Susan Jones, Racine; censor, Dr. R. W. McCracken, Union Grove; delegate, Dr. H. B. Keland, Racine; alternate, Dr. L. E. Fazen, Racine; president-elect, Dr. C. O. Schaefer, Racine.

The following doctors were duly elected members of the Society: Thos. L. Johnston, Samuel J. Fabor, C. C. Atherton, H. E. Breckenridge, G. S. Flaherty, Frederick B. Western, Herbert G. Brehm and G. C. Channess.

The program was as follows: Traumatic Surgery of the Extremities,—movie. Enforcement of the Medical Practice Act by Mr. Walter A. Drews, investigator, State Board of Medical Examiners.

The regular meeting of the Racine County Medical Society was held at the Racine Elks Club on Thursday evening, Jan. 15th, 1931 at eight o'clock.

Dr. Harry G. Walters of Racine was duly elected a member of the society.

Dr. Chester Schneider of Milwaukee, was the principal speaker of the evening. His address was illustrated with x-ray slides, and chalk talks, showing the methods of reducing and treating hip fractures.

Drs. R. M. Kurten and F. C. Christensen, Racine, gave very interesting accounts of clinical cases.

The attendance was fine. S. J.

ROCK

Members of the Rock County Medical Society and Rock County Bar Association held their first joint meeting at the Monterey hotel, Janesville, Tuesday evening, January 13th, the session being in the nature of a friendly get-to-gether and an effort to elevate professional standards. The occasion was dignified by the presence of five members of the state supreme court, Justices Fowler, Fairchild, Nelson, Wickham, and Fritz.

Other legal representatives from outside the county were Gilson Glasier, Madison, secretary of the Wisconsin Bar association, and Arthur McLeod, Madison, clerk of the supreme court. Two Madison medical men were on hand, Dr. William Stovall, director of the state laboratory of hygiene, and Dr. Erwin R. Schmidt, professor of surgery at the University of Wisconsin. J. G. Crownhart, secretary of the State Medical Society, and editor of the Wisconsin Medical Journal, also was a guest.

Following dinner, Ernest C. Fiedler, Beloit, attorney, spoke for the lawyers in welcoming the physicians, and in addition stressed the desirability of maintenance of high professional standards in the practice of both law and medicine. Frank McNamara, formerly of Janesville, and now an attorney in Milwaukee, expressed his appreciation of being with his friends here once more.

The meeting was replete with humor, each profession making quips at the expense of the other. Eight Beloit doctors, headed by Dr. C. F. Schram, staged a burlesque trial, making ludicrous various legal practices.

Dr. Arthur J. Cramp, Chicago, head of the bureau of investigation of the American Medical Association, the principal speaker, gave an illustrated talk on the topic, "The Patent Medicine and Public Health." City Manager Henry Traxler gave the address of welcome and P. J. E. Wood, local attorney, was toastmaster. The attendance numbered 125.

GREEN BAY ACADEMY OF MEDICINE

The Green Bay Academy of Medicine held its December meeting in St. Vincent's Hospital, Green Bay. Dr. W. H. Bartran of Green Bay presented a report of a case of Vincent's Angina infection of the hand.

MILWAUKEE ACADEMY OF MEDICINE

Dr. Harry R. Foerster was installed as president of the Milwaukee Academy of Medicine on January 13th at its annual meeting held at the University Club, succeeding Dr. G. V. I. Brown. Dr. R. W. Blumenthal was chosen president-elect to take office in January, 1932.

Other officers elected were: Dr. D. E. W. Wenstrand, vice-president; Dr. N. Warren Bourne, secretary; Dr. Ralph P. Sproule, treasurer; Dr. E. A. Smith, librarian.

The following were chosen as council members: Dr. Fred Stratton, Dr. J. J. Pink, Dr. John O. Dieterle, Dr. E. W. Miller, Dr. Ralph E. Morter, Dr. Carl W. Eberbach.

Committee chairmen appointed by Dr. Foerster were: Program, Dr. Forrester Raine; library, Dr. R. M. Greenthal; milk commission, Dr. H. O. McMahon; budget and finance, Dr. Ralph Sproule; life membership, Dr. Gilbert E. Seaman; new building, Dr. G. V. I. Brown; meetings, Dr. Carl W. Eberbach.

MILWAUKEE PEDIATRIC

The 26th regular meeting of the Milwaukee Pediatric Society was a dinner meeting held at the new Milwaukee Children's Hospital Convalescent Home, Waukesha County.

Dr. Eben J. Carey, professor of anatomy, Marquette University Medical School, talked on "The Inter-relation of Muscle Function with Bone Development and Pathology."

Officers elected for the ensuing year are: President, Dr. H. O. McMahon; vice-president, Dr. J. H. Reynolds; secretary-treasurer, Dr. F. R. Janney. F. R. J.

UNIVERSITY OF WISCONSIN

Dr. H. T. Hardgrove of Fond du Lac addressed the January 15th meeting of the University of Wisconsin Medical Society in the Service Memorial Institute. His subject was "The Vincent Problem in Mouth Infections."

NEWS ITEMS AND PERSONALS

Dr. E. B. Elvis, formerly of Medford, is now in general practice at San Antonio, Texas. His address is 1838 West Gramercy Place.

—△—

Dr. R. J. Portman, Marshfield, left the early part of January for Vienna, where he will devote six months to the study of eye, ear, nose and throat diseases.

—△—

At the first annual banquet of the newly formed Sheboygan Press Club held on January 7th, Dr. Otho Fiedler, president-elect of the State Medical Society, was one of the principal speakers.

—△—

Dr. E. R. Schmidt, of the University of Wisconsin, addressed a meeting of the American Business Club at Madison on the history and advance of surgery.

Dr. and Mrs. Reginald H. Jackson, Madison, entertained at dinner on January 3rd for Governor and Mrs. Walter J. Kohler.

—△—

Dr. and Mrs. F. C. Suiter of La Crosse sailed on January 9th from San Francisco for a trip around the world, their objective point being Java, where they will spend several weeks. Other points included on the itinerary are Honolulu; Kobe, Japan; Shanghai; Hongkong; Manila; Singapore and Naples. From there they will tour Europe. They expect to return to La Crosse about May 1st.

—△—

Under a plan adopted by the committee on unemployment of Racine, free legal advice is made available to the unemployed of Racine. A committee composed of two lawyers, two real estate men and the county probate judge has charge of a division which gives advice to unemployed facing foreclosure suits and other suits for indebtedness.

The committee also intends to confer with the Racine County Medical Society seeking free medical services for the unemployed and their families.

—△—

Dr. and Mrs. W. C. Comee, Green Bay, spent Christmas in Chicago with Mrs. Comee's mother and relatives.

—△—

Formal opening of the new hospital conducted by Doctors F. T. Clark and Kenneth Swartz of Waupun was held on January 1st.

—△—

A Buick sedan, owned by Dr. D. M. Gallaher, Appleton, stolen from the side of his office building on December 30th was found the following day in front of St. Elizabeth hospital. The car had not been damaged.

—△—

Mr. J. G. Crownhart, secretary of the State Medical Society, gave an address over WHA, University of Wisconsin, on December 30th, on the subject of "Contagious Diseases."

—△—

Two new members have been named to the staff of St. Mary's Hospital, Madison. They are Dr. M. H. Wirig and Dr. A. G. Sullivan, both of Madison.

—△—

Mrs. Leeta F. Oliver, wife of Dr. James B. Oliver of Ripon died suddenly on December 19th.

—△—

More than 110,000 specimens were sent to the State Laboratory of Hygiene and its branches for analysis during the fiscal year 1928–29, Dr. W. D. Stovall, director, Madison, declared in his biennial report.

—△—

Dr. R. O. Peterson, Racine, has removed his offices from 1503 Washington Avenue to 213–6th Street.

—△—

August Metchet, alias Jerry Metcher, Sheboygan, was fined $425 and costs in municipal court, Appleton, on charges of practicing medicine without a license, upon complaint of Mr. Walter Drews, investigator for the State Board of Medical Examiners. On Feb. 8, 1930, Metcher was convicted in Sheboygan and fined $100 and costs on the same charge.

—△—

Dr. Warren Stratman–Thomas, former member of the University of Wisconsin medical staff, was in Madison late in December gathering data on the score of cases of malaria that occurred in and near Madison last summer. He conferred with Dr. C. A. Harper, state health officer, and Dr. F. F. Bowman, city health officer, while in Madison. Dr. Stratman-Thomas is completing plans for a two-year study of malaria in the Florida swamps.

—△—

Dr. H. A. O'Brien, formerly associated with Drs. J. W. and C. H. Boren of Marinette, is now located in Dallas, Texas.

A 15 year old Clintonville boy was killed on New Year's Eve when police frustrated an attempt to extort $10,000 from Dr. A. H. Finney of Clintonville. The youth was killed when he ignored the command to stop as he fled with the dummy pouch deposited by Dr. Finney at the place designated in the boy's letter.

—△—

Because of illness, Dr. Philip Fox of Madison, who was named honorary chairman of the inauguration ceremonies of Governor Philip F. La Follette, was unable to be present.

—△—

A joint mass meeting for county health officers and the general public was held on January 9th by Doctors W. J. Miller and H. M. Guilford of the State Board of Health, in the business men's rooms in the city hall of Portage.

—△—

Appointment of Dr. Francis Paul, for the past year assistant physician at the Wisconsin Central State Hospital, Waupun, as superintendent of Normandale, Madison, was announced by the board of directors on January 8th.

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Dr. Walter J. Meek, professor of physiology, University of Wisconsin, gave an address before the Kiwanis Club of Baraboo. He spoke on "The Gentle Art of Poisoning."

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Dr. Lawrence C. Davis, a graduate of the University of Wisconsin Medical School in 1929, has opened an office in Richland Center.

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Friends of Dr. and Mrs. R. V. Landis, 120 S. Oneida street, Appleton, heard late in December of the tragedy that had befallen them. Within forty hours, Dr. and Mrs. Landis lost their two year old daughter Marjorie, and their four year old son Ralph, from scarlet fever and complications.

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Dr. N. B. Wagner of Racine recently moved into new offices at 523 Main Street.

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A total of 15 cases of tularemia were reported in Wisconsin in 1930 as compared with but five in 1929, according to a statement by the bureau of communicable diseases of the state board of health.

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Dr. H. K. Tenney, Madison, addressed a meeting of pre-school and kindergarten mothers of Dudgeon school, Madison, on the subject of "Child Feeding."

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William Horner was found guilty by a municipal court jury at Oshkosh of practicing medicine without a license and using the title "doctor." He was fined $1,000 and costs and sentenced to two years in prison. For more than two years he had been selling medicines of his own manufacture. Mr. Walter A. Drews, investigator for the state board of medical examiners, uncovered evidence that brought about the conviction. Horner had been convicted of the same offenses in Appleton and Manitowoc.

The 15th annual clinical session of the American College of Physicians will convene in Baltimore, March 23-27, and in Washington, D. C., March 28, 1931. As an added feature of the clinical session this year, an additional day, March 28, will be spent in Washington, D. C., where a special program of clinics and inspection tours has been arranged under the auspices of the Medical Departments of the U. S. Army, U. S. Navy, U. S. Public Health Service and Georgetown University.

Mr. E. R. Loveland, 133-135 S. 36th Street, Philadelphia, is the executive secretary of the College and requests for further information should be addressed to him.

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Dr. H. A. Keenan, Stoughton, has been promoted from the rank of major to lieutenant colonel in the medical reserve corps, according to a recent announcement by the war department.

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Dr. F. L. Weston, Madison, was elected president of the Y. M. C. A. board of directors at its annual meeting late in January.

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Dr. C. A. Harper, state health officer and president of the State Society, addressed the annual meeting of the Wisconsin Hairdressers' Association at the Ambassador Hotel, Milwaukee. His subject was "What the State Board of Health Means to the Cosmetician."

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Dr. Charlotte C. Calvert, director of the bureau of child welfare, State Board of Health, spoke before a January luncheon meeting at the La Crosse County Community Council.

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The Reedsburg Hospital, which has been closed for several months except for emergency cases, was reopened on January 15th.

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Dr. L. Levitt of Washington Park Community Hospital, Chicago, is now located in the village of Butternut.

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Dr. J. Rhodes Longley, Fond du Lac, was elected to membership in the Radiological Society of North America at the Sixteenth Annual Meeting held in Los Angeles, Calif., December 1 to 5, 1930.

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Dr. K. W. Doege, past president of the State Society, was re-named president and chief of staff of St. Joseph's Hospital, Marshfield, at the annual meeting of the staff on January 12th. Other officers elected were Dr. H. H. Milbee, vice-president and Dr. W. G. Sexton, secretary.

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Dr. M. N. Pitz, Neenah city health officer, spoke on "Noise" before a meeting of the Neenah Kiwanis Club.

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Disciplinary powers of the dean of men and the dean of women at the University of Wisconsin have been transferred to a faculty committee of which Dr. William F. Lorenz, Madison, was named a member.

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Dr. V. W. Koch, Janesville, returned on January 8th from a two weeks' stay in Philadelphia and Washington, D. C., where he visited clinics.

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The Mercy Hospital staff of Janesville elected the following officers at its annual meeting: President, Dr. A. H. Pember; vice-president, Dr. William H. McGuire; secretary-treasurer, Dr. Carl Neupert.

MILWAUKEE

Dr. and Mrs. A. W. Gray will leave for Florida early in February.

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Dr. O. T. Schultz, pathologist at Columbia Hospital, discussed "The Coroner System of the United States," at a meeting of the Professional Men's Club on January 13, 1931.

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Mr. and Mrs. Maurice Altman vacationed in Florida during January.

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Dr. C. C. Schneider appeared for the Speakers Bureau of The Medical Society of Milwaukee County, before the Fernwood Parent-Teacher Association on January 12. His subject was, "Why the Foot is the Most Abused Part of the Human Body."

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Dr. Samuel Plahner spoke before the Nee-Ska-Ra Pre-School Association on "Some Problems in the Training of Young Children." This meeting was held on January 12.

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Supt. Lawrence C. Austin, Mt. Sinai Hospital, spoke to the Fourth and Fifth District Nurses Association on January 13. His subject was "The Relationship Between the Nursing Care of the Patient and the Hospital Administration."

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Dr. J. P. Koehler, Health Commissioner, spoke before the St. Robert's Parent-Teacher Association on "The Health of Children."

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Dr. Edith G. Hamilton was appointed official Y. W. C. A. physician in December. She will conduct all physical examinations of the girls and women who wish to participate in the Y. W. C. A. physical educational program.

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Dr. and Mrs. Carl W. Eberbach spent the holidays at Ann Arbor.

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Dr. and Mrs. Harry Foerster who have been in Florida, have returned to their home. Dr. Foerster is recovering rapidly from a recent illness.

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The engagement of Genevieve Catherine Conerton, daughter of Representative and Mrs. Edward

Conerton of La Salle, Ill., to Dr. Jerome W. Fons of Milwaukee was announced on December 27.

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The Children's Convalescent Home operated in connection with the Children's Hospital of Milwaukee, located on Highway 59 west of the city, was opened on December 22.

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The addition of a fifth floor to the Evangelical Deaconess Hospital of Milwaukee at a cost of $120,000 was announced on January 4 by Harvey R. Habeck, Treasurer and attorney for the Evangelical Deaconess Hospital Society of Wisconsin which operates the institution. The new floor will be devoted entirely to surgical and maternity cases. It will be roofed with glass to provide daylight illumination. From eight to ten operating and delivery rooms will be provided in addition to other necessary rooms. The removal of the present operating room to the new floor will provide space for 20 additional private rooms for patients.

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Mrs. Lillian P. Tobias of Pittsburgh, Pa., has announced the engagement of her daughter to Dr. Sail I. Waxmer of Milwaukee. Dr. Waxmer is a graduate of Marquette School of Medicine and is now interning at Mt. Sinai Hospital.

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Mr. and Mrs. Wm. Gaterman announced the engagement of their daughter Laura to Dr. G. Alan Kriz of Milwaukee.

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Dr. G. H. Jurgens presented a paper on "Tuberculosis of the Skin" at the staff meeting of Muirdale Sanatorium held on January 7, 1931.

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Free medical service sponsored by the Medical Society of Milwaukee County continues during December and January at the Goodfellow House, a home for homeless and unemployed men. The following physicians served: Drs. Millard Tufts, L. M. Warfield, Jack Kinsey, Joseph Russell, E. T. Harrington, Edw. J. O'Neill, Elmer Gramling, Emmett Cook, P. L. Callan, W. J. Voellings, Harry M. Hawkins, Harry Tabachnick, P. M. Currer, R. C. Schodron, Bruno Warshauer, John Haug, A. R. Langjahr, E. L. Haberland, Alfred Suhr, Robert Wheelihan, J. J. Curtin, Paul Brehm, P. E. Oberbreckling, and M. B. Byrnes.

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The first meeting of the new Public Health Advisory Committee of The Medical Society of Milwaukee County was held at the Johnston Emergency Hospital on January 8. The principal subject of discussion was the proposed campaign in the interest of periodic health examinations. The health department has offered to co-operate with the medical profession and an intensive effort will be put forth.

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At a board of directors meeting of The Medical Society of Milwaukee County the following committees which had been appointed by Dr. E. L. Tharinger, president of the Society, were approved:

Health Council

Dr. Ralph P. Sproule, Chairman
Dr. W. F. Grotjan—1931
Dr. R. W. Blumenthal—1932
Dr. H. J. Gramling—1933 Dr. Millard Tufts—1934
(Only appointment to Health Council for 1931 is Dr. Sproule)

Sub-Committees of Health Council

Educational Committee
Dr. R. W. Blumenthal, Chairman
Dr. A. J. Patek — Dr. C. C. Schneider

Child Welfare and Public Nursing Committee
Dr. Millard Tufts, Chairman
Dr. H. O. McMahon — Dr. H. B. Miner
Dr. N. E. McBeath — Dr. R. S. Cron

Health Department Advisory Committee

Dr. H. J. Gramling, Chairman
Dr. G. H. Fellman — Dr. Wm. Kearns
Dr. E. F. Peterson — Dr. J. A. Jenner

Committees

Physicians Service Bureau
Membership Committee
Dr. H. E. Webb, Chairman
Dr. Jos. C. Griffith — Dr. Paul Brehm
Dr. S. R. Mitchell — Dr. R. W. Garens

Physicians Service Bureau
Advisory Committee
Dr. W. F. Grotjan, Chairman
Dr. J. J. Curtin — Dr. A. R. Langjahr
Dr. A. R. F. Grob — Dr. Maurice Olsen

Legislative Committee
Dr. Gilbert E. Seaman, Chairman
Dr. J. Gurney Taylor — Dr. Dexter Witte

Program Committee
Dr. Francis D. Murphy, Chairman
Dr. C. W. Eberbach — Dr. Edwin B. Gute

Social Committee
Dr. James C. Sargent, Chairman
Dr. J. F. Shimpa — Dr. S. M. Mollinger
Dr. H. O. Zurheide — Dr. Oscar Lotz

Committee on Collection Service
Dr. C. M. Echols, Chairman
Dr. John W. Powers — Dr. R. A. Toepfer

Membership Committee
Dr. R. P. Schowalter, Chairman
Dr. Mark Bach — Dr. J. L. Garvey
Dr. Stephen Cahana — Dr. Edwin Habbe
Dr. W. J. Carson — Dr. W. P. O'Malley

Medical Economics Committee
Dr. E. L. Tharinger, Chairman
Dr. Chas. Fidler — Dr. M. H. Boley

Plans for the new collection service to be sponsored by The Medical Society of Milwaukee County will receive immediate consideration by the newly appointed committee on Collection Service. Dr. Chester M. Echols, Chairman of this committee, called the first meeting at the City Club on January 10, when preliminary plans were discussed.

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Dr. I. Franklin, formerly Milwaukee County coroner, is in Vienna for a postgraduate study in urology.

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Dr. Carl Henry Davis, returned early in January from the Pacific northwest where he gave talks before the following societies: Portland Academy of Medicine; Portland Obstetrical and Gynecological Society; King County Medical Society, Seattle; Spokane County Medical Society. These addresses were given as one of their special lecture courses which these societies arrange each winter.

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A testimonial dinner was tendered Mr. J. S. Janssen by Milwaukee physicians late in December. Mr. Janssen was one of the early pioneers in the field of Roentgenology in Wisconsin and at the conclusion of the dinner was presented with a book of letters and telegrams from his many friends among the medical profession.

The following addresses were given at the dinner: For the Citizens, Mayor D. W. Hoan; for the Roentgenologists, Dr. F. W. Mackoy; for the Medical Profession, Dr. G. E. Seaman; for the Medical Organizations, Dr. C. A. Harper; Presentation, Dr. R. W. Blumenthal and Response by Mr. J. S. Janssen.

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Dr. Sidney J. Silbar, 530 Wisconsin Ave., addressed the Y. M. C. A., on January 10th. His subject was "The Physiology of Sex."

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Mrs. Augusta S. Smith, mother of Dr. E. A. Smith, Superintendent of the Milwaukee County Emergency Hospital and Dispensary, died January 14, in Hamburg, Germany. She was in her 88th year.

Mrs. Smith was born in Germany and came to the United States many years ago. She was long a resident of Milwaukee and Madison and was one of the founders of St. Mark's Episcopal Church in Milwaukee. She returned to Germany a few years ago to live with a daughter. The daughter died last October and Mrs. Smith had intended to return to Milwaukee but because of illness was unable to do so.

Dr. Smith, in addition to his other duties, is librarian of the Academy of Medicine.

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Dr. E. C. Brumbaugh appeared for the Speakers Bureau of The Medical Society of Milwaukee County at the Exchange Club on January 14. His subject was "The Value of Human Life From an Economic Aspect."

Dr. and Mrs. Otto Foerster and Miss Frances Foerster will leave for Miami, Florida, in February where they will join Dr. Nelson M. Black. They will remain a month.

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Unusually good health was found among Milwaukee school children at the first examination since the Christmas vacation, according to Dr. G. A. Barth, head of School Hygiene Department of the Milwaukee Health Department. Of the 81,000 children examined 1,226 were found ailing, of whom 217 were excluded from school. Only 3 cases of cold were found. Skin diseases were the most numerous with 720. General health conditions, Dr. Barth stated, are much better than last year.

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Dr. and Mrs. Roland S. Cron will leave for Florida early in February.

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Dr. M. R. French, who has been director of Communicable Disease Division of the Milwaukee Health Department announced his retirement to take effect February 7. Dr. French has accepted a position as state epidemiologist with the New York State Board of Health. His headquarters will be at Albany.

Dr. French was graduated from the Iowa State Medical College in 1920 and for several years served in the Hygiene and Preventive Medicine Department at the University. He also was assistant epidemiologist in Iowa.

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Dr. R. E. Hickey, who has acted as Dr. French's assistant will fill the vacancy here until a permanent successor has been appointed through civil service examination.

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Dr. Samuel Plahner spoke before the Y. M. C. A. and the Y. W. C. A. groups in the Y. M. C. A. building on January 18. His subject was, "Understanding Human Nature."

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Meeting of the chairmen of all committees of The Medical Society of Milwaukee County was held in the Mariner Tower on January 13. Dr. E. L. Tharinger, president of the Society, acted as chairman and called the meeting to order. Those present were: Doctors Ralph P. Sproule, R. W. Blumenthal, Millard Tufts, H. J. Gramling, H. E. Webb, W. F. Grotjan, Gilbert E. Seaman, Francis D. Murphy, James C. Sargent, C. M. Echols, E. L. Tharinger, P. M. Currer, S. J. Seeger and Mr. Theodore Wiprud.

An outline of the proposed objectives and activities of the Society was presented. Considerable discussion in regard to various phases of the Society program followed.

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The new Physicians' Service Bureau membership committee of The Medical Society of Milwaukee County met at the executive secretary's office on January 12, to consider plans for enlarging the membership of the Bureau.

Dr. W. H. Halsey was appointed chairman of a special committee to sponsor a program in first aid instruction under the health council of The Medical Society of Milwaukee County. Dr. Halsey is well equipped to deal with this problem having given it considerable study.

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Plans in connection with the proposed Medical Arts Building on Third and Wells Streets are progressing. No definite details have been announced for the beginning of the construction as there are still some details to be ironed out.

Detailed announcement of the plans for this building will be forthcoming early in the spring. Mr. W. A. Gettlman of Milwaukee is its promoter.

It is planned that the Medical Society of Milwaukee County and the Milwaukee Academy of Medicine will be housed in this building and that an entire floor will be provided for them.

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The following talks sponsored by the Wisconsin State Board of Health and delivered by Mr. Theodore Wiprud, executive secretary of the Medical Society of Milwaukee County will be broadcast over the Milwaukee Journal Station WTMJ during February:

February 3, "The Eyes of Persons Past Sixty Years of Age."

February 10, "The Care of the Sick."

February 17, "Some Things Mothers Should Know."

February 24, "Exit Diphtheria."

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At a staff meeting of the Muirdale Sanatorium on January 21, 1931, Dr. L. L. Allen presented a paper on, "Miliary Tuberculosis."

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The free medical service sponsored by the Medical Society of Milwaukee County at the Goodfellow House, a home for homeless and unemployed men still continues. Since the first of the year the number taken care of by the House has increased. Sanitary inspection of the quarters is made daily by the medical officers of the Wisconsin National Guard. Dr. Wm. J. McKillip, Major, Ambulance Battalion 135 Regiment is in charge. Other officers serving are: Dr. Carl Wilske, Major, 121 Field Artillery; Dr. T. J. Howard, Captain, 135 Ambulance Battalion; Dr. N. W. Bourne, Captain, Hospital Co. 183; Dr. H. Nebel, Captain, 121 Field Artillery, and Dr. E. J. Carey, 1st Lieutenant, Hospital Company 183.

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The board of directors of The Medical Society of Milwaukee County met on January 9 at the executive offices. Consideration was given to the budget for the new year, which was presented by the executive secretary. The budget was approved. Plans for the coming of the Inter-State Postgraduate Medical Association of North America in October were discussed.

Dr. and Mrs. S. J. Seeger and family returned on January 5 from Texarkana, Texas, where they spent the holidays.

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Dr. Morris Fishbein, who has been conducting a course in medical writing under the direction of the University of Wisconsin Extension Division, in co-operation with The Medical Society of Milwaukee County, was taken suddenly ill on January 7 and was unable to conduct the session that day. He, however, improved and was able to conduct the class on January 12. There are 45 enrolled in this class.

BIRTHS

A son to Dr. and Mrs. Walter E. Meanwell, Madison, on January 10th.

A daughter, Mary Kendall, to Dr. and Mrs. J. W. Lambert of Antigo on December 30, 1930.

ENGAGEMENTS

Dr. Jerome W. Fons, Milwaukee to Miss Genevieve Catherine Conerton, La Salle, Illinois.

Dr. Sail I. Waxmer, Milwaukee to Miss Tobias of Pittsburgh, Pa.

Dr. G. Alan Kriz, Milwaukee to Miss Laura Gaterman, Milwaukee.

MARRIAGES

Dr. Damon A. Brown, Madison, to Miss Joyce Ball of Stevens Point on January 3rd at Madison.

Dr. O. A. Mortenson, Madison, to Miss Lila Embertson of Stanley on January 1st at Madison.

DEATHS

Dr. D. J. Ryan, Neenah, died on December 24th at Mercy Hospital, Oshkosh. He had been in poor health for more than a year but his death came unexpectedly.

Dr. Ryan was born in Saukville, Wisconsin, November 28, 1866. Following graduation from Oshkosh Normal School, he was superintendent of schools at Oconto for five years and then entered Marquette University Medical School. He received his degree in 1903 and began the practice of medicine at Algoma, remaining there for ten years. Later he engaged in practice for several years in Chicago. He came to Neenah in 1917.

Dr. Ryan was a member of Winnebago County Medical Society, the State Medical Society and the American Medical Association.

He is survived by his widow and one daughter.

Dr. John L. Shaw, Manitowoc, died on December 28th following an attack of apoplexy. He had been ill since last May.

Dr. Shaw was born at Chatham, Ontario, on July 2, 1869. As a young man he entered the British army and became an instructor in artillery, later taking up the study of medicine at Barnes Medical College, St. Louis, and graduating in 1893. He practiced medicine in Michigan and later in New York City. For eleven years he practiced in Martinton, Ill. In 1911 he came to Manitowoc where he remained until his death.

In 1929, Dr. Shaw served the State Medical Society as councilor of the fifth district. He was a member of Manitowoc County Medical Society, the State Medical Society and the American Medical Association.

He is survived by his widow and one daughter.

Dr. George F. Kenney, Milwaukee, died on January 12th at his home, 3481 N. Hackett Avenue. He had been in ill health for several months.

Dr. Kenney was born in 1884 at Cedarburg, Wisconsin, and came to Milwaukee when a young man. He was a graduate of Milwaukee Medical College in the year 1906. Following graduation he took postgraduate work at Rush Medical College.

The deceased was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Dr. Kenney is survived by his widow, one son and two daughters.

SOCIETY RECORDS

New Members

Ralph G. Mills, Fond du Lac.
F. O. Zillessen, Fond du Lac.
Chalmer Davee, River Falls.
Richard R. Jandrain, Wayside.
L. W. Peterson, Shawano.
D. D. Ruehlman, Monroe.
Joseph Grimm, 921½ Milwaukee Ave., S. Milwaukee.
George Light, 1100 Wis. Ave., Milwaukee.
Erwin L. Bernhart, 2405 Walnut St., Milwaukee.
Karl Friedbacher, West Allis.
Wm. A. Ryan, 1100 Wis Ave., Milwaukee.
W. P. O'Malley, 5920 North Ave., Milwaukee.
John G. Slaney, 111—34th St., Milwaukee.
Otto S. Blum, Monticello.
M. P. Ohlsen, Monticello.
J. H. Murphy, Clintonville.
W. H. Lipman, Schwartz Bldg., Kenosha.

Changes in Address

H. W. Lawrence, Janesville to 434 Christie St., Ottawa, Ill.

» » » CORRESPONDENCE « « «

BASIC BOARD TO MEET

STATE BOARD OF EXAMINERS IN THE BASIC SCIENCES
(Anatomy, Physiology, Pathology and Diagnosis)
Madison, Wisconsin, January 2, 1931.

Wisconsin Medical Journal,
Madison, Wisconsin.
Gentlemen:

The next examinations by the Wisconsin State Board of Examiners in the Basic Sciences will be on Saturday, March 21, 1931, at the Hotel Loraine, Madison, Wisconsin.

Examination application to be made to Robert N. Bauer, secretary, 3414 W. Wisconsin Ave., Milwaukee, Wis.

Very truly yours,
ROBERT N. BAUER,
Secretary, Basic Science Board,
3414 W. Wisconsin Ave.,
Milwaukee, Wis.

OWNERSHIP OF ROENTGENOGRAMS

AMERICAN MEDICAL ASSOCIATION
Chicago, December 30, 1930.

Sister M. DeSales, Superintendent,
Holy Family Hospital,
Manitowoc, Wisconsin.
My dear Sister DeSales.

Your letters of December 6 and 17, relative to the ownership of roentgenograms were duly received. I am sorry that it has been impracticable to answer your inquiries sooner. The work of this Bureau is, however, unusually heavy at the present time, and as the Bureau has to serve a membership of nearly one hundred thousand and must give precedence to the demands of the subordinate societies of the Association—that is, state and county medical associations—it is impossible to answer all inquiries immediately on their receipt. Then, too, many inquiries cannot be answered offhand, but require research before the necessary data can be assembled. I hope the following information may serve your purposes.

I

Have we the right to give out the patients' records or films on request of the physician, patient, R. R. or insurance companies, etc.?

Neither a railroad company nor an insurance company has any right even to inspect the records of a physician or a hospital, relating to patients. Obviously, then, a railroad company or an insurance company has no right to authorize the giving out of copies of such records. If a railroad company or an insurance company desires to inspect the records of a patient, including roentgenograms, or to obtain copies of the records of patients, including roentgenograms, it should be required to produce authority from that patient so to do, or if the patient is a minor or under guardianship, from the parent or

guardian. If notwithstanding such authority, the responsible officer of a hospital is still in doubt as to the propriety of giving out copies of a patient's record, the safest plan is to deliver the desired copy of the record to the patient himself, or to the parent or guardian, and to allow the patient, parent, or guardian, if he so desires, to deliver it to the railroad company or insurance company. The authority to be required of railroad companies or insurance companies with respect to this matter had better be in writing, in order to facilitate proof of such authorization, if necessary, although writing is not necessary to the validity of the authorization.

If a patient who has attained his majority and is of sound mind authorizes a physician or hospital to give to some third party a copy of the patient's records or roentgenograms of the patient, there is no legal reason why the hospital or the physician should not comply with the request. I know of no requirement, however, that the hospital or physician do so. If the preparation of copies of the records or of the roentgenograms involves expense on the part of the physician or hospital, he or it has a right to insist on compensation to cover such expense. If the patient is insane or under guardianship, or is a minor, authorization should come from the parent or guardian.

Generally speaking, there is no law that would prevent a physician or a hospital, on the request of a patient, from giving out the *original* records or roentgenograms, or in the case of a minor or insane person from doing so on the request of a parent or guardian, although it would certainly be highly inexpedient for the physician or hospital to do so. The original record should be preserved for the protection of the physician or hospital.

I know of nothing in the relation of a physician to a patient that empowers him to authorize a hospital, without the consent of the patient himself, or of his parent or guardian, to give to third persons records of his patient's illness or injury.

II

Are the reeords or films hospital property, or do they belong to the patient, by reason of their paying for same?

The accompanying reprint of an article that appeared in the Journal of the American Medical Association some time ago expresses generally the state of the law with reference to the ownership of roentgenograms. So far as I know, it is not customary for hospitals to charge patients for records, whether ordinary written records or roentgenograms. Such records as are kept are kept for the guidance of physicians and nurses in rendering service, and it is service that the patient pays for, not the mere incidents on which that service is based. One would hardly claim that a patient had a right to take away with him when he left the hospital all of the nurses' notes, temperature charts, reports of blood, urinary, gastric tests, etc., and other similar records. Why he should claim the right, then, to take away with him roentgenograms that have been made in his case is not clear, nor is it clear that he has any more right to take away a roentgenogram than he has to take away the other portions of the record.

Probably a patient has the right of access to the records that have been made in his case, so long as he exercises that right without interference with the orderly functioning of the hospital. Possibly, too, he has a right, on payment of the cost, to obtain copies of all such records. But whether this is or is not so, has never been decided, so far as I am informed, by any court of competent jurisdiction.

My own feeling is that a hospital holds its records somewhat in the nature of a trustee for its patients and for the physicians who attend them, and, in its own right, for its own protection.

III

Have I, as superintendent of the hospital, the authority to refuse giving out our films to the doctors or eompanies?

I know of no basis for any claim by any company of the right to demand of the superintendent of a hospital a copy of a roentgenogram of any patient in the hospital. When a patient is under treatment in a hospital, the parties to the contract for hospital service are ordinarily the patient and the hospital. No insurance company, no railroad company, nor any other corporation is a party to it.

A railroad, insurance, or other corporation, may have a contract with a patient in a hospital by which the patient seems to authorize the corporation to make examinations of the patient and may be of hospital records, etc.; or a corporation may realize that it is liable to be subjected to a claim by the patient because of some alleged wrong done by the corporation. In such cases, however, the hospital is not a party to the insurance contract or to the claim. If the corporation desires under such circumstances to exercise its right of examination of the person of a patient or of records relating to him, it should obtain from that patient, or if he be a minor or insane, from his parent or guardian, authorization for the hospital to permit the necessary examination of person and records.

If the patient, the parent or guardian, is willing that the examination be made, there should be no difficulty in obtaining consent. If the patient is not willing and refuses authorization, then certainly the hospital authorities should not undertake to go contrary to his wishes.

Moreover, the hospital authorities should hardly assume to act as interpreters of insurance contracts or of liabilities of corporations to claims for damages, and it would be necessary for the hospital authorities to do so if they should assume to permit the patient or his records to be examined against the patient's will on the basis of contracts between the patient and the corporation or claims by the patient against the corporation.

Whether hospital authorities have a right to refuse to give roentgenograms to physicians depends on the relation of the physician to the roentgenogram. It is conceivable even that a roentgenogram taken by a physician in a hospital belongs to him and not to the hospital, but that is a matter that would have to be determined by an examination of the relations of the physician and the hospital in each case. A safe rule always is to obtain the authority of the patient before giving out any of his records, although it is hardly likely that difficulty will arise if a roentgenogram was taken for the guidance of a physician in attendance upon a patient and that physician be supplied with a copy of it for his use away from the hospital, for purposes of consultation or otherwise. He should certainly be supplied with a copy of it, upon the assumption of the implied consent of the patient, if the copy of the roentgenogram is necsesary, to enable him to perform his professional functions.

IV

If the films can be given out and are lost or mislaid, will the diagnoses on pink and yellow sheets be legally accepted for x-ray findings?

Diagnoses on pink and yellow sheets can never be accepted for x-ray findings. If in court it can be shown that the roentgenogram has been lost, the law will admit in evidence the "next best evidence." What that "next best evidence" is will depend on the circumstances of the case. It will ordinarily be the testimony of those who took the roentgenogram, who studied it, and who came to some conclusion with respect to its meaning. Diagnoses on pink and yellow sheets might be helpful in supporting or disproving the testimony of such witnesses, but they alone would not be a substitute for x-ray findings. However, the occasions must be rare when a hospital having the lawful custody and control of the original roentgenographic film permits it to pass from its custody.

V

In case a record or film is given out, should that permission come through the superintendent or the technician?

This is altogether a matter of hospital internal management.

VI

If films are the exclusive property of the hospital, what means would you suggest to satisfy the doctor, insurance companies, R. R. companies, etc., in court cases? Would a print be satisfactory to all concerned?

Just what is meant by undertaking to "satisfy the doctor, insurance companies, railroad companies, etc., in court cases" is not clear. In court cases, the question is not that of satisfying the doctor, insurance companies, railroad companies, etc., but of satisfying the court. What must be done to satisfy the court is a matter of law. Even though the original roentgenographic film is the exclusive property of a hospital, its production in court can be compelled by the court through a subpoena duces tecum.

When an original roentgenographic film is produced in court, it still remains the property of the hospital, and the court itself cannot deprive the hospital of ownership of it except by process of law, and due compensation. The court can require, however, that the roentgenographic film be left in the custody of the court pending the determination of the case.

In introducing an original roentgenographic film in court, it is proper to take with it a print of that film. In that case, counsel and the court have an opportunity of comparing the print with the original roentgenographic film, and if they are satisfied that the print is accurate they will ordinarily permit the print to be substituted in the record for the film and the film to be returned to the files of the hospital.

Yours truly,

WM. C. WOODWARD,

WCW:JB Director.

"STATE MEDICINE"

New Richmond, Wis., Jan. 2, 1931.

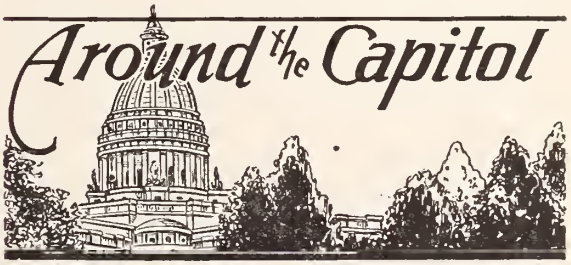
Mr. George Crownhart,
Secretary, Wisconsin State Medical Society,
Madison, Wis.

Dear Sir:

Dr. —. —. ——— has referred me to you for information on the subject of state medicine. I am a member of the women's debating squad of North Central College, Naperville, Illinois, and would greatly appreciate any material, whether it be for or against. If you have any information to give out, would you kindly send it to me in care of Johnson Hall, Naperville, Illinois?

Very truly yours,

(Miss) BERNICE BERND.



New low records in the Wisconsin mortality from diphtheria, typhoid fever and scarlet fever are predicted for the current year by the bureau of vital statistics, state board of health, but the auto accident menace will prove more serious than in 1929, when its toll stood at 701. The toll may reach 750 lives for 1930.

* * *

Data supplied by physicians who attended the 80 fatalities which resulted from diphtheria in 1929

has proved the necessity of giving toxin-antitoxin to all children over nine months old, according to the state board of health. Delay in administering the serum contributed to 67 of the deaths, the report said.

* * *

Laymen outnumbered physicians as health officers in Wisconsin 950 to 794 in 1929, the state board of health announced.

* * *

The urban population has out-distanced the rural population, according to a United States census report recently received at the office of the secretary of state. The population figures for Wisconsin are as follows: Total—2,939,006; Urban—1,553,843; Rural—1,385,163.

* * *

Alfred Hendrickson and his wife won their case in the supreme court against W. J. Newman and others, for workmen's compensation for the death of their son, Ferdinand, who was killed by lightning on May 18, 1928, at Dalton, in Sauk County. He was excavating a cellar for a new house, when a storm came on and he ran for shelter under a pine tree, which was struck by lightning. The supreme court affirmed decisions by Judge Zimmerman and the state industrial commission, which found that the death occurred while performing service incidental to the man's employment.

* * *

A search for new varieties of vegetables as well as bush and tree fruits suited to Wisconsin conditions is being planned. At its recent annual meeting the Wisconsin State Horticultural Society voted to petition the legislature to appropriate a sum of $5,000 to be used under the direction of the horticultural department of the university in research work toward developing new varieties and improving existing varieties of plant life suitable to Wisconsin conditions.

* * *

Rapid changes in transportation point to eventual government ownership of railroads with rail lines to remain a necessity even though their operation becomes unprofitable, in the opinion of A. R. McDonald, member of the state railroad commission. Wisconsin's railroad commission is one of the many bodies in the nation wrestling with the transportation problem. Private automobiles and busses and trucks have already driven many short lines out of existence. Many more are destined to go because automobile competition has robbed the short lines of passengers and freight.

* * *

The present industrial depression has so far affected Wisconsin much less severely than that of 1921 although it has already continued eight months longer than the previous disturbance, the industrial commission has announced. In 1921 aggregate weekly payrolls in the state plunged 56 per cent before the upturn came at the end of eleven months. In the present depression payrolls have dropped but 36.9 per cent at the end of nineteen months.

* * *

For the first time in nearly a quarter century the Wisconsin college of agriculture has a new dean. He is Chris Lauriths Christensen, 36, executive secretary of the federal farm board. He succeeds Harry L. Russell and will come to the university as soon as he can be released from his duties at Washington. He is an expert on co-operative marketing and his coming probably means that the college will take the lead in trying to solve farm marketing problems.

Public Welfare Committee Appointments of 1931 Legislature Are Announced; Important Bills Planned

Senator Walter H. Hunt of River Falls will be chairman of the Senate Committee on Education and Public Welfare and Assemblyman Don V. Smith of Jefferson will head the Assembly Committee on Public Welfare. These committees will hold hearings on all measures affecting public health and treating the sick. The full committees for the 1931 session follow:

SENATE COMMITTEE ON PUBLIC WELFARE

Senators Walter H. Hunt, River Falls, chm., Bernhard Gettelman, 955—50th St., Milwaukee; Walter S. Goodland, Racine; Conrad Shearer, Kenosha, and Peter J. Smith of Eau Claire.

ASSEMBLY COMMITTEE ON PUBLIC WELFARE

Assemblymen Don V. Smith, Jefferson, Chm., H. E. Stephens of Platteville; William A. Kay of Spring Valley; John L. Sieb of Racine; Mrs. Agnes Charbonneau of Superior; H. A. Aune of Baldwin, and Frank A. Kellman of Galesville.

HEALTH MEASURES INTRODUCED

While the great flood of bills to come before this session will not be introduced before the middle of February, the following measures have now been presented:

Senate Bill 30 S—By Senator Polakowski, Milwaukee. Provides that the provisions of the Workmen's Compensation Act are extended to cover cases of "childbirth by female employees and indemnity shall be paid as for total disability for a period extending from six weeks before to eight weeks after childbirth, during which period such employee shall not be permitted to work."

Senate Bill 33 S—By Senator Gettelman, Milwaukee. Provides for an investigation by the cor-

oner, or an inquest, in every case of death of an inmate of a state institution.

Assembly Bill 71 A. By Mr. Beggs of Rice Lake. Abolishes the panel of physicians under the Workmen's Compensation Act and provides for free choice. In discretion of Industrial Commission it may establish a schedule "of fees to be allowed physicians for various standard services" which shall also be maximum fees allowable except by special showing.

MATERNITY AID BILL

In presenting the measure for Maternity Aid (Bill 30S) the following statement was given to the press by Senator Polakowski:

"Three ways of aiding the Mother at childbirth are now in use in the leading foreign countries. The first method is that of providing the Mother, both before and after confinement, with skilled nurses, medical attendance and helpful advice.

"The second method is that of outright a sum of money on the birth of a child, the state supplying the funds.

"(This bill however is designed to operate the same as the actual workmen's compensation law benefits.)

"The list of countries having some form of cash benefit for Mothers during maternity is impressive; all of the larger and most of the smaller countries of Europe, as well as the commonwealth of Australia, have made provision for their women *Wage Earners*, these countries are Australia, Austria, Bosmia, Denmark, France, Germany, Great Britain, Herzegovina, Hungary, Italy, Luxemberg, Netherlands, New Zealand, Norway, Roumania, Russia, Serbia, Sweden, and Switzerland, the action of these countries is not a matter of recent date; the national insurance system of Germany began with the year 1884, though there was provision by local governments before the date, Austria in 1881—and Hungary in 1891 adopted plans similar to the German.

"The British and Australian plans simply grant a specified sum to the Mothers, to be paid on proof of the birth of a child. This method simplifies the administration, but the reports of the operation of the laws seems to indicate that it produces less satisfactory results. The weekly sick wage payment plan makes it possible to require the Mother to refrain from factory or other work under penalty of withholding the benefit.

"In a majority of the countries the Mother is provided with free medical attendance and medicine, though in some of the larger countries such as Great Britian, no such aid is furnished.

"The main intent of this bill is to keep the Mother from factory or other work for compensation.

"The benefits to be paid same as workmen's compensation as provided for by law, and the contention is that it will be of great benefit both physical and financial during the maternity period."

Council Holds January Meeting to Outline Year's Program; Budget Approved; Dr. Arthur Rogers Re-elected Chairman

MEETING OF THE COUNCIL

Milwaukee, January 3, 1931

1. The Council was called to order at nine-thirty, Saturday morning, January 3, 1931, by the Chairman, Dr. Arthur W. Rogers, Oconomowoc. Roll call showed the following present: Councilors Rogers, C. A. Harper (also President of the Society), Spencer Beebe, F. W. Pope, R. W. Blumenthal, F. G. Johnson, Wilson Cunningham, Joseph F. Smith, A. H. Heidner, F. Gregory Connell, H. M. Stang; President-elect Otho Fiedler, Speaker of the House W. D. Stovall, K. W. Doege, Treasurer Rock Sleyster, Dean C. R. Bardeen and the Secretary, Mr. Crownhart. Absent: Councilor T. J. Redelings (in California).

2. It was moved by Smith-Pope that the minutes of the September meetings be approved as printed in the Wisconsin Medical Journal, October, 1930. Carried.

3. *Elections.* a. Upon nomination of Harper-Beebe, Dr. Arthur W. Rogers, Oconomowoc, was elected to succeed himself as Chairman of the Council.

b. Upon nomination of Smith-Blumenthal, Mr. George Crownhart of Madison was re-elected to succeed himself as Secretary of the Society and Council with a continuation of the present salary of $8,000, of which amount $6,800 is appropriated from dues and $1,200 from the receipts of the Wisconsin Medical Journal.

c. Upon motion by Smith-Harper-Blumenthal, Dr. Rock Sleyster, Wauwatosa, was re-elected Treasurer of the Society and Council with an honorarium of $300 annually.

4. *Report of the Secretary.* The Secretary presented his report as follows:

Dear Doctors:

We will close the year with 2,187 members, two over a year ago. Our delinquents number 51 as compared to 37 for 1929. It is gratifying to notice that the component societies are everywhere using the utmost caution in accepting and passing upon applications for membership. As result, our list of members is constantly being used by concerns everywhere in need of medical services as the best available means of procuring aid of reputable men interested in keeping abreast with scientific progress.

THE JOURNAL

A financial report of the Wisconsin Medical Journal will be distributed at the meeting. It appears that the Journal will have a small deficit for the year which will be met from its $4,000 working

fund. This deficit was foreseen two years ago when the Editorial Board approved a slight increase in the advertising rates effective for new advertisers on January first, last, and for the great group of our old advertisers on January 1, 1931. The increased income from this source in 1931 will make up any deficit for the future.

It will be remembered, except for a small sum for the extra printing involved in publishing the Transactions, the Journal has been self-sustaining for the past three years. It has a separate accounting system and pays from its own receipts $1,200 for the salary of the Managing Editor, $300 for rent, all costs of cuts and the many other costs of publishing. It has accumulated a working capital of $4,000. Prior to 1923 the Journal cost the Society upwards of $5,500 a year. This has been wiped out representing a savings of four-fifths of the entire salary of the Secretary-Managing Editor.

During this same period the Journal has materially increased its size and no article is refused because of the costs of publication.

SALARY OF THE SECRETARY

By letter to the La Crosse County Medical Society, copies sent to the Council, Councilor Beebe has indicated his belief that the entire salary of the Secretary is not generally known to the members. He recommends that the entire salary be listed in the Budget.

The entire salary of the Secretary has been published in the Wisconsin Medical Journal annually except for the present year when it was presented orally before 47 county medical societies of the 50 in the state. So that there may be no question about it, the letter from Dr. Beebe is published in the Correspondence Column of the January Journal. Every member is entitled to know all details of the finances of his Society.

It is suggested by Dr. Beebe that instead of the salary being shown on divided statements it should be given in its entirety on the Budget of the Society. The Budget, however, represents the planned use of such moneys as come to the Society from dues. From this source $6,800 is expended for the Secretary's salary, in addition to relieving the Society from any costs in connection with the Journal as a whole. The Budget figure could not well be changed unless the Council wishes to assume the payment of the entire salary from dues and have the Journal remit $1,200 a year to the Society as an added source of income. If the Council believes such procedure advisable it will be adopted.

SCIENTIFIC WORK

A special report of the scientific work of the Society was sent to the Council this fall. For purposes of Journal publication it will be considered an addenda to this report. A subsequent report by Dr. K. W. Doege, Chairman of the Special Committee on Scientific Work was mailed on December 27th. Is it the wish of the Council that the Committee be now continued or discharged?

ACTIVITIES OF THE SOCIETY

Today there is no member of this Society that has not had his dues returned him in perpetuity as result of but three accomplishments of the group.

I have the very earnest conviction that the Society will accomplish that which is potentially possible, only as it reflects in its activities the needs and desires of the great group of its members. That such activities comprehend guarding and fostering the material welfare of the members as well as promoting scientific work is evident. The one must not be accomplished at the expense of the other and in preparation of the Budget the Council is the body that must approve a balanced program for the year.

PRESSING PROBLEMS

Furtherance of a better scientific service to the public will ever be a problem of the profession. I have no thought that its importance should be minimized. While I have made no recommendation, if it seems presently desirable that we further extend our scientific activities I would urge that our first step be the securing of a part-time scientific editor for the Journal. I assume the approximate cost would be $2,500 a year. From the point of view of bettering the scientific section of the Journal, I believe the money could be well spent. This is no more intended as any reflection on the generous and voluntary services of the present Editorial Board than on myself as Managing Editor. I am attempting to point out that which seems to me to be the next step in the furtherance of scientific work in this state. Whether the Society desires to extend its program of scientific work at this time is entirely a matter for its officers to determine. This item, it will be noted, was not included in the Secretary's suggested budget for the year.

As a layman in daily contact with other laymen in all walks of life, as well as with the profession, I am more and more impressed that today they are increasingly conscious of and concerned about the distribution of the costs of medical care. (See addenda 1.) Periods of economic pressure but emphasize this problem of distribution of costs which is common to all people who have not substantial savings —the millions as compared to the hundreds. Few will question that we are in the midst of a social period which has as its end providing a better measure of economic security for all people. Voluntary compensation insurance for accidents of industry now followed by labor's proposal for a state fund with compulsory provisions, voluntary old age pension system now followed by the proposal for a compulsory provision, the proposal for a compensation system for automobile accidents, and the proposed compulsory provision for unemployment insurance, all have in view securing a better measure of economic assuredness for the great mass of citizens. It would seem that these but prepare the way for some measure designed to protect against the uneven costs of that most common accident of all—illness.

The entire proposal for the increase in dues from $10 to $15 rested basically upon the conviction that this and other problems of the present and future cannot be equitably solved in the legislative halls unless they are given greater study during other times. I believe that such effort is worthy of every dollar spent and that it will return dividends to the members in the future as have our group efforts in the past. It cannot be demonstrated, nor must we so expect, that any organization such as this can show what any given appropriation will accomplish in terms of dollars and cents. Rather must we view what has been accomplished during the past to make conditions for practice in Wisconsin favorable, and consider as results of a broad future program those favorable conditions which exist in this state but which do not so exist elsewhere under apparently like conditions.

If we grant that each member has an average investment in education and equipment of $10,000, then the State Medical Society of Wisconsin is the only state organization that by constitution and activities is responsible for the future income of the total investment of twenty-two millions of dollars, as well as responsible for an unselfish forward looking program that will better the public health.

THE BUDGET

The Council has before it the recommendations of its Budget Committee. I am in full accord with their expressed desire for an economical expenditure of the funds which are provided by many members at some immediate sacrifice. By the same token I believe we should make every effort to make wise expenditures for a constructive program, the principles of which have been so generally approved by the members in their own component societies. To that end I offer the suggestion that a full year's program be outlined with provision that certain projects be withheld in execution until it is certain that the funds are available. I do not favor building a further surplus except from year to year by that margin of safety that good business demands of any budget. Desirable as it may be as an end in itself, I do not feel that present projects should be deferred unless it seems essential to withhold the increase in dues for another year.

CONCLUSION

As your Secretary, I am employed by the Society to accomplish your desires. The vision of any single man wrapped up in his work may easily become narrow and his views fail to represent those of the body. This I have tried to avoid, and in pledging my best efforts for such program as the Council sees wise to adopt, so am I conscious that they mean little without the generous support of every officer and member which has brought to the Society every measure of success as may have been presently attained.

Respectfully submitted,

J. G. CROWNHART,
Secretary.

Addenda 1.

If one examines titles of some of the articles relating to medical services appearing in lay magazines during the year, one is impressed by the similarity of subject matter: How Necessary is Illness? A Cure for Doctor's Bills, a Constructive Plan; Even Doctors must Live; A Patient Looks at Doctors; Cost of Caring for Britain's Unfit; Cost of Hospital Service Lowered; A Doctor Diagnoses the Bills; An Economist Audits his Costs; The Enjoyment of Ill Health; Health without Wealth or Hospital for Middle Class; A Professor Prices Babies; A Merchant Looks at Medicine; Public Health vs. Private Practice; Industry's Answer (How a Railroad Safeguards its Employees in Health and Sickness); Pioneers Plow a Way; Health on Horseback in Lebanon; Private Group Clinics; Middle Class Hospitals and Clinics; Insure for Health; The High Cost of Nursing; Facts to Face the Future (Subtitle: The task of the Committee on the Cost of Medical Care); More Hospitals for Veterans?; What Hospitals Get?; Publicity and Medical Ethics; Preventive Private Practice; County Societies Cooperate; Cleaning up the Clinics; Mental Health at Moderate Cost; When Doctors Disagreed; and Medical Care for 34,000 People.

Addenda 2. SCIENTIFIC WORK

Inasmuch as the Special Committee on Scientific Work has been continued at its request to permit of further inquiry into the possibilities of increasing the scientific services of the Society, the Secretary has made this compilation of present services rendered and available. The basic thought in this bulletin is to give such an outline as to make possible further suggestions for the future.

1. *Medical Extension.* During the war period the legislature gave a grant of $5,500 yearly for medical extension effort. Well organized by Dr. Rock Sleyster, by 1922 the funds were no longer under his direction and were being diverted to non-essentials so that they were providing material of little or no value to the general membership. While it was possible to secure speakers, each county society had to pay at least $25 which removed the activities from the very societies which most needed the Fund's aid. As result of continuous effort by the State Society during 1924-25-26, the use of the fund was completely reorganized and is now administered under a joint advisory committee comprising the executive staff of the Extension Division, representatives of the Medical School, and officers and a special committee of five representing the State Medical Society. During the years since reorganization and ending July 1, 1931, the amount made available for the work has been in the neighborhood of $7,500 annually. This is now used as follows:

A. *Lecture Service.* The Society's contention on cost was admitted and today any county or district society may secure any member of the faculty or preceptorial staff of the University Medical School without one cent of expense. The faculty donates

its services (the only faculty of the University so to do), and all expenses of travel are paid from the Extension Fund. The number of meetings furnished with speakers each year has now grown to approximately one hundred.

B. *Medical Library Service.* This service, instituted upon request of the Secretary, is today possibly the Society's greatest scientific accomplishment. In addition to the financial grant from the Extension Division, an additional $3,000 is given by the Medical School. With this total of from $5,500 to $6,500 the Library offers four services:

(1) The loan of recent literature on any given subject by packets made up from a subscription list of over 300 leading medical journals. Cost to the physician is postage and wrapping both ways.

(2) Loan for limited period of given journal or journals each month. Cost to physician is ten cents a month.

(3) Compilation of bibliographies or list of references on a given subject. Cost to physician is 60 cents an hour but inasmuch as such lists are now in readiness for all leading subjects, present cost is only for the time needed to bring the list to date.

(4) Loan of books from the Extension Library, the Medical School Library, or securing them from one of the national institutions. Cost is postage and wrapping both ways.

C. *Short Courses.* The Joint Advisory Committee has approved the plan for occasional short intensive courses at the University for review. These courses will be financed on a fifty-fifty basis by physicians attending and the Extension Funds. The fee will be nominal and the first course will likely be held in 1931.

D. *Postgraduate Medical Extension Classes.* A seven-year program outline is submitted (see last sheet) which concisely covers the work in the field. It will be remembered that this is financed on a fifty-fifty basis between the attending physicians and the Fund and that the average cost to the physicians for the series of twelve weekly lectures and clinics is $30.

E. *Special Clinical Centers.* It has been proposed to bring to Wisconsin, from time to time, special clinical teams to give a series of six lectures and clinics in one week in six geographical centers of the state. The immediate proposal is to bring Banting and others on the subject of Insulin this coming spring. While the Medical School and State Society are underwriting the proposal, the Extension Division will give, without charge, the aid of solicitors so that the maximum attendance can be secured for each center.

F. *Future Plans.* The Joint Committee has recommended that the Legislature be asked to increase the budget for Medical Extension by $4,500 a year to make the total $10,000 a year. The Committee has in mind the employment of a full-time director of activities at $3,000 and $1,500 additional for the free lecture services. While it was thought that securing any additional allowance was highly improbable, it has just been passed by the Budget Committee of the Regents and, after something of a fight, by the Regents as a whole. It now goes to the Legislature with the approval of the University regents. This would mean, if the grant is approved, that, beginning July 1st, next, there will be spent in Wisconsin $13,000 a year from state funds for the furthering of medical extension in this state. No other state has anything approaching this budget.

2. *The County Medical Society.* Eight years ago it may be said that inability to secure program material of the type desired, at a cost within their means, kept fully one-half of the fifty-one county medical societies as paper organizations. Today the only inactive societies may be said to be Door where there are but five members, Clark with 14 members, LaFayette with 14 members, Iowa with 13 members and Price-Taylor with 11 members. Clark and Price-Taylor have previously been active and there seems to be no reason why they will not again function this fall.

It is generally true that the average society is having a fourth more meetings today than a few years ago.

3. *The District Meetings.* A few years ago but few districts had an annual district meeting. The Ninth District where Dr. Jos. F. Smith has long had four excellent meetings each year was a notable exception. For the past three years each district has had an excellent meeting and they now appear to be firmly established as a means of securing program material of a calibre that the average county society would be unable to have.

4. *The Annual Meeting of the State Society.* A. Eight years ago the annual meeting did well that had an attendance of 450 members. Today, according to Dr. Olin West, Secretary of the American Medical Association, no constituent state medical society has a larger attendance at its meetings in proportion to size than does Wisconsin with one-third of all members present.

B. In the last four years Wisconsin has inaugurated a further change that some other states are noting with interest. Instead of accepting voluntary contributions and filling the larger part of the program with the so-called imported material, Wisconsin chairmen are now deliberately calling upon Wisconsin members to contribute the greater share of the program. The purpose is, of course, to build Wisconsin medicine. At the 1926 meeting there were, for example, 15 speakers from without the state and only 11 from Wisconsin. Note that in 1929 this had been reversed with 25 from Wisconsin and 15 from without. In 1930, this year, we had but 8 out-of-state speakers and 26 from Wisconsin with 9 others leading round table discussions and 66 others partaking in the dry clinics on Friday morning.

C. In 1923–24–25–26 we were spending about $2,000 on the meetings—just what we received from exhibitors. Today we are spending what we receive from exhibitors and $2,000 more from the general funds of the Society. No program chair-

man in the last three years has asked for expense money for speakers and failed to obtain it.

5. *Secretaries' Conference—Bulletins.* In the last few years we have reinstated the annual Secretaries' Conference. At first they were just luncheon meetings during the annual meeting. Then we separated them to allow a full day, the State Society paying about one-quarter of the travel expense. Today we pay all the travel expense and have a most representative gathering. At these conferences program material, number of meetings, attractive features, etc., are all discussed and emphasized.

This annual session is supplemented by an occasional bulletin from the State office to all county and state officers. Program material available is listed in almost every bulletin. In addition, the State office regularly suggests programs to county societies upon their request.

6. *The Wisconsin Medical Journal.* All members are familiar with whatever progress the Journal has achieved. In the last eight years its size has been doubled and where the annual bill for cuts was around sixty to seventy dollars, today it is upwards of $500. No manuscript from Wisconsin members has ever been rejected for lack of space or for financial reasons.

Where the Journal used to cost the Society in the neighborhood of $6,000 a year, today it pays its own way. There may be a slight deficit this year but it will not exceed $100. It is of interest to note that the New York State Journal of Medicine has, the last two years, made more extracts from The Wisconsin Medical Journal than from the Journal of any other state.

It will also be remembered that a new policy was adopted two years ago providing that, with the exception of annual meeting papers, Wisconsin manuscripts will be given a wide margin of preference over any out-of-state papers. This policy has increased the publication of Wisconsin papers by about the same proportion as cited for the last two annual meetings.

ADDENDA 3

WISCONSIN MEDICAL JOURNAL

Madison, Wisconsin

BALANCE SHEET

December 31, 1930

ASSETS		
Current Assets		
Commercial National Bank	$1,469.51	
* Accounts Receivable	1,596.46	
Total Current Assets		$3,065.97
Investments		
Bonds		975.00
Fixed Assets		
Office Equipment	98.00	
Less: Allowance for Depreciation	19.60	
Total Fixed Assets		78.40
Prepaid Expense		
Postage Deposit		58.57
Total Assets		$4,177.94
LIABILITIES AND NET WORTH		
Current Liabilities		None
Net Worth		
Surplus		$4,177.94
Total Liabilities and Net Worth		$4,177.94

* The account receivable due from A. M. A. for December advertising is included herein on an estimated figure furnished by them of $291.46. Therefore "Accounts Receivable and Advertising Income" are subject to correction when the definite amount is determined. Subject to this correction the balance sheet and operating statement reflects the condition of the Wisconsin Medical Journal on December 31, 1930, and the operating results for the year.

WISCONSIN MEDICAL JOURNAL

Madison, Wisconsin

OPERATING STATEMENT

Year Ended December 31, 1930

INCOME		
Advertising	$9,205.02	
Subscriptions	160.90	
Miscellaneous	6.00	
Interest	27.00	
Total Income		$9,398.92
EXPENSE		
Salaries	$1,571.21	
Printing	6,806.11	
Mailing	224.02	
Cuts	384.05	
Rent	300.00	
Miscellaneous Expense	45.00	
Accounting Service	195.00	
Discounts Allowed	45.30	
Depreciation	9.80	
Bad Accounts	25.00	
Total Expense		$9,605.49
Net Operating Loss for Year		$ 206.57

Upon motion of Cunningham-Heidner the report was accepted with the provision that the salary of the Secretary be paid as previously ($6,800 from dues and $1,200 from the receipts of the Wisconsin Medical Journal).

5. The report of the Treasurer was read and accepted as follows:

TREASURER'S REPORT

STATE MEDICAL SOCIETY OF WISCONSIN

As at December 31, 1930

	General Fund	*Medical Defense Fund*
Bal. Jan. 1, 1930	$ 140.18	$ 186.03
Receipts during year 1930	25,095.26	2,980.00
	$25,235.44	$ 3,166.03
Disbursements during year	24,984.99	1,215.77
Bank Balance in Funds Dec. 31, 1930	$ 250.45	$ 1,950.26

RECAPITULATION OF FUNDS

General Fund:		
Bank Balance as of Dec. 31, 1930	$ 250.45	
Investment Securities	20,000.00	20,250.45
Medical Defense Fund:		
Bank Balance as of Dec. 31, 1930	1,950.26	
Investment Securities	5,000.00	6,950.26
Total cash resources as of Dec. 31, 1930		$27,200.71

INVESTMENT SECURITIES

General Fund:		
Northern States Power Co. 1941—5%	$ 4,000.00	
T. M. E. R. & L. Co. 1961—5%	2,000.00	
Milwaukee Gas Lt. Co. 1967—4½%	2,000.00	
American Tel. & Tel. Co. 1936—4%	4,000.00	
Wis. Tract. H. L. & Power Co. 1931—5%	3,000.00	
Wis. Public Serv. Co. 1942—5%	3,000.00	
Canadian Nat'l Ry. 1969—5%	2,000.00	20,000.00
Medical Defense Fund:		
Commonwealth Edison Co. 1957—4½%	2,000.00	
Pacific Tel. & Tel. Co. 1937—5%	1,000.00	
Bell Tel. of Canada 1955—5%	2,000.00	5,000.00
Total Bonds		$25,000.00

Analysis Medical Defense Fund:		
Bal. Jan. 1, 1930	186.03	
Receipts, dues	2,740.00	
Interest on bonds	240.00	3,166.03
Paid to Hoyt, Bender, McIntyre & Hoyt	1,180.77	
Paid to Wylie & Whipple	35.00	1,215.77
Bank Balance Medical Defense Fund Dec. 31, 1930		$ 1,950.26

a. The Secretary was asked to furnish the Council with quarterly statements as to the details of expenditures under the medical defense fund.

6. *Committee on Public Policy.* Dr. Otho Fiedler, Chairman, presented the report of the Committee on Public Policy (see Wis. Med. Journ. Jan. 1931). It was moved by Pope–Stang that the Committee be instructed to use its best efforts to carry into effect the instructions of the 1927 House of Delegates so as to accomplish a reorganization of the State Board of Medical Examiners without reference as to sectarian schools as qualification upon the membership; except that the present representation of one osteopathic member should be maintained. Carried. It was moved by Cunningham–Smith that the report as amended be accepted. Carried.

7. *Committee on Cancer.* The following report of the Committee on Cancer was presented by Chairman W. D. Stovall and upon motion by Connell–Pope, was accepted as to its recommendations:

To the Council:

This committee has for several years been actively engaged in an educational campaign to inform the public on the menace of cancer and how to some extent it may be controlled. The educational work has consisted of the distribution of literature and public lectures on the early recognition of cancer with the recommendation that a physician's advice be sought early.

This campaign has resulted in arousing a widespread interest in the subject and has been to some extent responsible for the increased activity of scientific investigation into the cause, diagnosis and methods of treatment of cancer. The interest of the public has been so aroused that men of wealth have been willingly giving large sums of money to support all phases of the work. State and city governments have in many instances appropriated money for the purpose of the advancement of research into the cause, diagnosis and treatment of cancer.

In this state, so far, no definite plan has been formulated either by the state or medical profession to meet the cancer problem. The committee is, therefore, convinced, because of the importance of the problem and because of the experience in other states and in some cities throughout the country, that we should not be inactive on this problem.

The committee, therefore, recommends:

(1) That a sum of five hundred dollars be set aside for expenditure by this committee to be used to advance the technical skill of physicians throughout the state in the recognition and treatment of cancer. Already the question is being asked: Are the rank and file of physicians sufficiently informed on the difficult problems involved in the diagnosis and treatment of cancer to care for the cases that are being sent to their offices by the lay educational campaigns conducted by various private agencies? Some of this money we would spend for a cancer exhibit and clinic for the annual meeting. The rest would be used to solicit funds for broadening this activity and for lay educational work as the advancement of information warrants.

(2) The committee further recommends that the American Association for the Control of Cancer be invited to make a survey of the facility in this state for the care of cancer patients and the study of the disease. In order to officially bring this request before the American Society for the Control of Cancer, we suggest the adoption of the following or similar resolutions:

Whereas, The rapid increase of cancer in its various forms is assuming alarming proportions, now being second only to heart disease as a cause of death; and

Whereas, The present cancer situation is a challenge to the medical profession to render an increasingly effective service in its diagnosis and treatment; and

Whereas, The greatest hope for reducing the increasing mortality from this disease lies in diagnosis and treatment in early stages; and

Whereas, The medical profession and the hospitals are the only forces capable of coping with the cancer problem at this time; and

Whereas, There is need for further education of the medical profession and the public as to the need for and value of early diagnosis and early adequate treatment; and

Whereas, A constructive program of improved cancer service can be based only on accurate information as to the present professional and institutional facilities for the diagnosis and treatment of this disease; therefore, be it

Resolved, That the Council of the State Medical Society of Wisconsin approve and sponsor a survey of the cancer situation in Wisconsin, and that the American Society for the Control of Cancer be requested to make such a survey, reporting its findings with recommendations to this Society.

Respectfully,
W. D. STOVALL, M. D.,
Chairman.

8. (Dr. H. E. Dearholt now present). Dean Chester D. Snell of the Extension Division of the University of Wisconsin presented the present situation with reference to post-graduate instruction in the state for the summer of 1931, asking Council advice. After a full discussion it was moved by Smith–Connell that it be the recommendation of the Council that during the coming summer the regular schedule of post-graduate education under the seven year committee plan be moved ahead one year and that one day clinics in diabetes as approved in the September Council meeting be substituted therefor. Carried.

The Council recessed at 12:15 for lunch.

The Council was called to order by the Chairman at 1:30 with Dr. Oscar Lotz, Dean McGrath and former President Fred Gaenslen now present.

9. *Report of the Special Committee on Scientific Work.* Dr. K. W. Doege, Chairman, presented the following report of the Special Committee on Scientific Work was ordered filed and upon motion of Stang–Harper, the committee was continued.

Marshfield Clinic,
Marshfield, Wis.
December 24, 1930.

Mr. J. G. Crownhart,
Madison, Wisconsin.
My dear Mr. Crownhart:

On my return from abroad I found your letter of October 24th, addressed to the Special Committee of Scientific Work. (Secretary's Note—This was sent to all members of the Council). It is a splendid exposition of what has been accomplished in the past for the profession of Wisconsin by those in charge of the State Medical Society and by its Journal, and the recommendation for the future shows understanding and vision. In my opinion there is nothing that can be added to it.

If it could be worked out so that a large percentage of the physicians of the state could and would avail themselves of the opportunities offered by the Journal and by the state, the benefit that would accrue to medicine in Wisconsin would be great indeed. To what extent and how thoroughly Wisconsin physicians do make use of the Journal has always been and still is an unanswered question. If one would canvass the offices of Wisconsin physicians, look at the Journal and see if it had been read one might get an approximate idea on this point. But such a canvass would not appeal to everybody and the proposition cannot be entertained. The Board of Editors of the Journal can have no definite idea how thoroughly the Journal is read because, as I understand, there is usually but little expressed appreciation by the readers or personal correspondence between the readers and the Editorial Board. My own impression is that the pages containing the scientific articles are but slightly thumbed. Assuming this to be a fact and without looking for an explanation of this phenomena it would lead up to the necessity of finding a remedy.

If what is generally understood as state and industrial medicine is something that in its operation works harm to the individual physician (I do not say that it actually does do so) then it behooves each physician to search for the cause why the state and the laity are so intent on invading a field in which they evidently at first must be strangers. To my mind this cause is easy to find. It lies in the rapid widening of all the branches of what is commonly known as medicine. It now takes more than an ordinary mind to have a working insight in all its branches. The State and the laity fully understand our shortcomings and have undertaken to do what we have failed to accomplish. To this activity in some of its phases we most strenuously have objected. But to rely on legislation to protect our interests is to me a most foolish endeavor and, if successful, could only be of temporary benefit. If the state, the great industries and the organizations, who dabble in medicine for profit only, do things medical better than we are doing it, it behooves us to show them what we can do and rise to the occasion by fitting ourselves for the larger medical problems that in our short-sightedness we may have overlooked.

It is and always has been the aim of the State Medical Society and its branches to increase our professional efficiency and to augment our economical and social importance to the community and to the state. As to the means to be employed to accomplish this end there is a wide difference of opinion among the leaders of the state organization. To my mind this can only be accomplished by making of ourselves better and more farsighted physicians.

As chairman of the Committee on Scientific Work, and with the above end in view, I have been requested to write a circular letter, which, after having been submitted to the committee for sugges-

tions, was to be mailed to the members of the State Medical Society. At the committee's meeting in Milwaukee, September 19th, specific suggestions were made; such as, the employment of a full-time scientific secretary, employment of a part-time scientific secretary, establishment of midwinter clinical meetings to be held in various parts of the state and finally the establishment of a consultation bureau for members. No doubt each of these would be of benefit if properly used.

Personally, I can see only one thing that will be of immediate and lasting benefit and that is what I have advocated for the past two years; i.e., the employment by the State Society of a medical secretary whose duty it is to create, lead and keep up the interest in the progress of scientific medicine among its members throughout the state. These duties to be in contradistinction to those interests that pertain to the business part of our profession, at present so ably being taken care of by you, Mr. Crownhart.

In the letter before referred to and under the heading of "future plans" you say: "the joint committee has in mind the employment of a full time director of activities." If the committee is thinking of a medical man for this position, I am heartily in accord with it. To my mind it requires the personal contact of a *physician* with the general practitioners to keep up and stimulate the interest in matters of clinical and scientific medicine. A man of the laity for this position would be a sad mistake. From him we can not reasonably expect enthusiasm nor can he expect us to have confidence in him and his vision in matters medical.

Were we to judge the status of medicine in Wisconsin solely by the number of meetings held, by the size and appearance of our Journal, by the amount of money spent for cuts in the Journal, by the postgraduate courses given, we could know that Wisconsin medicine as compared with previous years has made considerable progress but in doing so we would judge but superficially. The statistical figures tell us nothing of the depth of the aims and ambitions of the individuals, which after all is the main thing. In this connection let us not forget that the prime of Wisconsin medicine when Senn and his contemporaries were living, lies in just those past years that we compare ourselves so haughtily with, and where we had none of the many activities enumerated in your letter of October 24th.

I hope, Mr. Crownhart, that my letter to you could be manifolded and sent to the committee and council and if approved be published in the Journal. Perhaps we might hear what other physicians of the state think of the employment of a full-time or even part-time "medical" director and associate editor of clinical and scientific medicine of Wisconsin, a director who is not a layman but a physician, and a man with vision.

Cordially yours,

K. W. DOEGE, M. D.

10. *The Budget.* Treasurer Rock Sleyster presented the report of the Budget Committee item by item. This was approved in all but two instances: a. The Committee on Cancer was granted its appropriation of $500 which the Committee had recommended for postponement; b. An Assistant Secretary was authorized 10–1 which the Committee had recommended for indefinite postponement. By subsequent motion of Stang–Connell, an appropriation of $2,500 was made to the Editorial Board. The budget as then approved item by item, was approved as a whole upon motion of Harper–Cunningham. Carried unanimously. The Budget, as approved, follows:

1.	Rent	$ 960
2.	Supplies, phone, telegraph, postage, printing, etc.	2,200
3.	Travel, Secretary	450
4.	Salary, Secretary*	6,800
5.	Salary, Florence Ripley	1,680
6.	Salary, Ellinore Beck	1,650
7.	Salary, travel, Ass't. Secretary	3,000
8.	Treasurer, accountant	300
9.	Hygeia presentations	450
10.	A. M. A. Delegates	300
11.	Secretaries' Conference	1,200
12.	Legal services	500
13.	Committee on Public Policy	2,000
14.	Annual Meeting	1,800
15.	Council, rail fares	300
16.	Foundation Fund	600
17.	Committee on Cancer	500
18.	Editorial Board	2,500
19.	Press Service	2,750
	Total	$29,940

Income: The income from 2,000 members is $30,000. The interest from surplus is $800. Free balance—$860.

* The Secretary also receives $1,200 from the Wisconsin Medical Journal which is self-supporting.

11. It was moved by Blumenthal–Beebe that the President of the Society appoint a committee of three to consider ways and means of erecting at Prairie du Chien a memorial to Dr. William Beaumont, as urged by Dr. William Snow Miller before the general sessions of the 1930 anniversary meeting. Carried.

12. The Secretary presented a letter from the American Medical Association urging close co-operation between state medical societies and narcotic officers to the end that drastic national legislation might not become necessary. The Secretary was directed to correspond with the State Board of Medical Examiners to the end that criminal violators of the narcotic act shall have their licenses revoked.

13. Upon motion of Blumenthal–Smith, Drs. Edward Evans, J. A. L. Bradfield and A. A. Maurer of La Crosse were elected to honorary membership as suggested by the La Crosse County Medical Society.

14. The Secretary was instructed to send flowers and greetings of the Council to its former Chairman, Dr. Edward Evans. Motion by Sleyster–Connell.

15. The Secretary presented a letter from the Medical Society of Milwaukee County asking that the State Society accept an invitation to endorse

and act as hosts for the 1931 meeting of the Interstate Post Graduate Medical Assembly.

16. The Chairman of the Council was given authority to appoint a committee to make suggestions to the May Council meeting on "Council Awards" to be granted for distinguished service at the 90th Anniversary Meeting.

17. President Harper submitted suggested legislation to create a Medical Grievance Committee. Upon motion of Stang–Blumenthal the Council approved the introduction of the measure.

There being no further business, the Council adjourned until May, subject to call of the Chairman, at 4:40 P.M.

J. G. CROWNHART,
Secretary.

Approved: ARTHUR W. ROGERS, M. D.,
Chairman of the Council.

Beaumont Memorial Committee

Pursuant to Council action, President Harper of the State Medical Society of Wisconsin, has appointed Dr. Curtis A. Evans, Milwaukee, Dr. F. J. Antoine, Prairie du Chien and Dr. William Snow Miller, Madison, as a special committee to present recommendations on a memorial to Dr. William Beaumont to be situated at Prairie du Chien on the site of old Fort Crawford. Dr. Curtis Evans is to act as chairman of the committee which will present its recommendations before the 1931 House of Delegates meeting at Madison in September.

Wisconsin physicians will recall that a plea for such a memorial was made by Dr. William Snow Miller before the general sessions at our last annual meeting and following his remarks the Council of the Society authorized the appointment of this committee, the purpose of which would be to suggest the form of the memorial and to outline suggested ways and means of erecting it.

The essence of Dr. Miller's plea was the fact that St. Martin was brought to Prairie du Chien in August, 1829, at great expense and it was really here, during the subsequent three years, that Beaumont laid the foundation of his work on digestion. Memorials to Beaumont have been placed at Lebanon, Mackinac, Plattsburg and St. Louis but there is none in Wisconsin.

This Man--The General Practitioner*

By HARRY M. HALL, M. D.
Past President West Virginia State Medical Society
Wheeling, West Virginia

"Why are they tearing down his sign?" said the Interne on Parade.

"To turn him out, to turn him out," the Noted Surgeon said.

"What makes you look so queer, so queer?" said the interne on Parade.

"I am dreading what I've got to watch", the Noted Surgeon said.

"For we're hanging the General Practitioner you can hear the Dead March play.

The surgeon's meeting's in the room—they're emasculating him today.

They've taken all his patients—they've humbled him their way.

And they're killing off the Practitioner in the morning."

Apology to Barrack Room Ballads.

I do not know how you gentlemen feel about the term "General Practitioner" but as for me I have come to loathe it. I have experienced moments of detachment when in the spirit of the classical vendetta I should have liked to have retaliated with some such mild epithet as "fragment healer", to those who saw fit to malign it. But this is the era of turn the cheek in medicine and I have eventually succeeded in quelling the vulgar tendency.

"General Practitioner" was once a grand old pair of words, full of all the love, veneration and respect an appellation could hold. Not a couplet in the language meant more than it. Alas! How words can fall from high estate and no one to give reverence in their declination. How subtle it has been—this grievous change. I dare say the motor car assisted in the transformation. In any event it came before many of its victims were aware of it. And now today, what was yesterday a compliment to any man, is ashes in

* Presented before 89th Anniversary Meeting, State Medical Society of Wisconsin, Milwaukee, Sept. 1930.

the mouth and every interne who leaves his hospital spends many an hour calculating how he can go out and best avoid it. For he has first hand information on the matter and has learned who looks on while others work and reap the glory. I daresay too you have all noticed the comic figure so much in evidence in the newspapers cartoons of the day. Drawn in smaller stature than the other participants in the picture, he usually has a little hat too small for his head; has a large mustache grotesquely out of proportion to his small features. His glasses suggest astigmatism. Inferiority hangs over him like a second-hand halo. He stands hesitant. Indecision is his. A fatuous look wreathes his countenance. All in all he bespeaks a vacuum. What futility! What forlornness! The artist labels him "Common Citizen", "Mass Voter" or "The Public". Mr. Gerard said recently that fifty-nine powerful men controlled him. As a rule he is depicted being patronized by shrewd politicians or imposed upon by the malefactors of great wealth.

Some way or other from some hidden source the hint has been promulgated that the above description also fits the general practitioner's plight in medicine. Articles appear describing his passing out of the picture in language strangely like the obituary notices. His gradual decay in importance, especially as it applies to the country doctor, is made the cause for sentimental reminiscences of other days and is couched in words marking his replacement as one of the interesting episodes in Medicine today. *If all this were so the reflection would be on MEDICINE, not him.* It seems he was once adequate. Now he is inadequate. He represents the diastolic in medical efficiency while his modernistic one track colleague of today admits he is the systolic. Between the two is the pulse pressure of professional activity. You may doubt this, but, if you do, your decision will be met with a cold, stony stare from the cathedrals of medical learning which will fix you and humble you as thoroughly as if it had come through the monocle of a German officer or the bejeweled lorgnette of a social success.

Strange, is it not, that in all the comparisons made between these two the practitioner is always cited at his worst, the other at his best. The successful general men in big cities of whom I have known and who have for many years performed all their own surgery and who treat a clientele which could afford whatever it wanted are never placed side by side with a sallow faced, robot-like fellow who follows nonchalantly the readings of an electro cardiograph with the same enthusiasm displayed by a linotypist.

GROUP PRACTICE

As for me, I am still one of the unregenerate few who can see no difference in the appraisement of an alert, up-to-date general practitioner fully competent and aware of the best in what's extant and that evaluated by a foundation or a group. I know this view is old-fashioned and betokens my senility, still I hold fast to it; although I do believe the general practitioner should have one to four colleagues with whom he is in sympathy so that the physical side of his life will be comfortable and liveable. Notwithstanding the heraldings of the group, I will maintain a very necessary and all important personal element is dissipated by far off denizens journeying to a place that knows them not. The prevalent argument is that this personal element does not matter and may be disregarded. In the case of a ten pound fibroid it would be so. But many another situation would involve the personal equation to a striking degree and all would depend upon it. I could never understand why a Baltimore citizen should have to go to Boston and a Clevelander to Rochester when at each place is a group that stands for the highest there is in their field. Just as mystifying is the variance in diagnosis given by different clinics on conditions which are more or less obvious as for instance—pansinusitis. One may be absolutely a denial of the other. It is no uncommon thing to be an attendant at a great medical assemblage and hear two authorities on the gall bladder, for example, come out and refute each other's experiences on the same platform on the same day.

This is not a perfect world and fallibility is a universal trait. No one expects these

great persons to hit the bull's eye every time. Nor is the above recital aimed as a criticism of their work. But we must remember the very reason they came into being and are replacing the general men, is that by passing through the gamut of a lot of experts and finished men, error was to be eliminated and precision, definitian and clarity, combined with expert treatment, was to be almost perfectly attained. As long as it has not by a good deal of margin, the old timer may have his say and remain within his rights. It is, however, amusing to find that when failure, which is difficult to tack onto a whole crowd, does issue from a foundation, it comes laden with the news that at least all that could ever be done in this world has happened whereas, when it is calibrated against a single practitioner, it is charged up to lack of knowledge. It is surprisingly like poor investments. The will of the late Chauncey Depew, recently probated, revealed his estate was well sprinkled with worthless mining and oil stocks. It was lightly and quickly passed by as negligible. Had a plain doctor have left them, comment headed his departed way would have referred to him as a fool.

PHYSICAL FACILITIES

It is claimed the general practitioner lacks the facilities. It is a well-known fact too many tools bespeak a poor workman. The greatest painters have worked in very simple media. The simplest and plainest doctor's office I was ever in was that of the great Charles F. Hoover of Cleveland. Nevertheless, the general man is supposed to be short of instruments of precision, take poor histories, and be singularly lacking in a full blown knowledge of what goes on in a laboratory. Let us look into these claims. The men by whom general practioners should be judged are entirely and completely conversant with all instruments of precision except the electro-cardiograph and their lack here is due to their failure to have access to the paraphernalia. Many general hospitals do not have an apparatus. They quickly made use of the blood pressure instrument. Fifty percent of the general men I knew had an instrument shortly after their introduction. Not only that but it was not the heart specialists who found out the stethoscope was not everything it was "cracked up to be" and that murmurs and heart sounds were not the whole thing in cardiac lesions. That remained a task for general practitioners of the better sort to do in the late war. History taking is an abused art. I know it is heresy to say so but it is carried to absurd lengths. Some of them resemble a biography. I hazard the guess they are only indifferently read and sometimes not at all by those under whose name they appear. Their chief use is in the writing of long medical articles in which tiresome details are given and only the summary read by the recipient. Obscure assistants dig the facts out for the author. It is a physical impossibility for great men with a stupendous amount of operative or diagnostic work to accomplish to read long histories. They are therefore abstracted by a lesser light and sent up to them and in the carrying up of this matter is where the personal equation goes a-glimmering. Here the question arises, "Is the view of a third or fourth assistant any better than that of a good general practitioner?"

Next we may ask, "Is it a physical possibility for the heads of great institutions to personally see all the patients that come to them?" The foundations admit this is not possible. But it seems that it is given to them also to read human character and worth—so that even without an Edison test they can pick "yes men" who will correctly interpret their outlook. The impossibility in this lies in the fact—namely that the men who founded clinics, groups and foundations were great men. There is no question about that. They represented the flower of their profession. They had individuality, brilliancy and super-ability. Other men, by placing themselves in their reflected light, confess at once they have not these qualities in the same degree. As time goes on it will develop into an organized machine where the various members will, figuratively speaking, await for the whistle to blow.

The general man can never equal the reputations of the heads of institutions, it matters not how competent he is. Unless he gets his babies mixed in a hospital, he is ruled off the front page. It is practically impossi-

ble for him in the present state of affairs to have a national reputation for anything. Being unable to gain the meticulous as regards a fragment of pathology, his name must remain local. But is the meticulous necessary? I recall Dr. Myron Metzenbaum of Cleveland, who fixes noses so beautifully, remark "that he learned all his principles by watching the general surgeons" and that he therefore thought they were all that was necessary to have. He even emphasized the fact that he made his attack on the septum according to the rules of the general surgeon and not obliquely as did the rhinologists.

Some day when surgery is more civilized it will be found a few well laid laws will suffice to guide an operator in every part of the body. In the meantime volumes on surgery will be as full of diverse designs as the contents of a wall paper store. On the other hand, the general practitioner avers that a diagnosis in a group picture loses a lot of the personal element and there is no way by which you can as yet assort all the various reports in a series of experiences with different clinicians so they will correlate with any unity. That mistakes might easily happen in shuffling the cards that would compare with his own misdemeanors.

THE LABORATORY

Last we have the laboratory. It is an absolute necessity no one denies that. No one would care to practice medicine without one at his back. But there are those hypersensitive souls in medicine as there are in golf and religion, who make a fetish out of trivialities. Unless you hit the ball as they do, or were baptized as they were immersed, you are among the lost. They are rampant in medicine over the unfamiliarity the general practitioner shows about some of the minor procedures. They hold them up as a bugaboo. They offer a long list as a final triumph in the collective bargaining of the moderns.

I fancy it is unorthodox to say so but I believe only a comparatively few of the many are of downright value to anybody. A lot of the obscure ones are so intricate in performance, and require such conscientious observers to read them that the results in mediocre hands are quite likely to do more harm than good. But there they are—with heroic surnames attached to them, the plague of students in examinations—and there they will remain to clutter up medical literature until the appointed hour of courageous house cleaning shall come. They are nothing more nor less, a lot of them, than mystifying feats by scientific prestidigitators to confuse the general practitioner, who is somewhat humiliated by the legerdemain. They bear no more relation to the actual curing of disease than do the performances of a magician, like Thurston, do to real life. General practitioners of the representative type have always employed the best there is in the bacteriological and pathological sciences. Realizing they had not the time to personally conduct the various procedures they have supported laboratories everywhere. But most of them with very little extra effort could do the necessary ones themselves with slight post-graduate participation. It is the useless fringe; the excessive embroidering of it all, they decry.

Many general practitioners still use the oral method of administration at times. This seems to be discredited by the moderns. Many doctors do not know where the nearest prescription drug store is to be found. It is somewhat novel to see a medical man, who once upon a time was a drug nihilist, now furiously giving about every drug and chemical by way of the intramuscular or intravenous route. Some way or other it was the bottle and spoon he hated, not the drugs. Nevertheless, it was really the general man in the old days of arsephenamine administration (and perhaps the vaccines in their heyday) who really brought those methods into common use. Blood transfusions and spinal punctures are commonly employed by many general men, although there is still a large contingent who remain wary of them.

DIAGNOSIS

General men therefore of the progressive sort are quite alive to all new methods of diagnosis and treatment and it must be understood that where they are mystified and perplexed, those to whom they finally refer the cases are also quite frequently upset by indecision. It is in these rare cases that the

man of limited practice proves his worth and it is never the purpose of this writer to minimize it. No one can deny his importance. But that is no reason why the whole picture should be visualized by such men. Rapidly made diagnoses in many situations are impossible. I believe that general men make more and better ones than the specialized groups. The popular belief is quite to the contrary. Some way or other, and it is really an unfair anticipation, many people expect the great groups to give them a complete yellow ticket of all that is the matter with them in forty-eight hours. They have passed this along to a demand on the general man to do likewise. Of course he cannot. There is no more reason in asking him to do it than to have the priest or preacher at a nuptial event demand of the bride and groom if they could tell him all that they expected their marriage to imply. They could prophesy, as can any fool, but it would be hazardous.

But it is not always the patient who demands an immediate diagnosis under trying conditions in the home and factory. The surgeons and internists have the habit too. So you will frequently find in extensive articles on appendicitis, foreign bodies in the lung, sinus thrombosis following acute mastoiditis, elaborate tables showing procrastination on the part of the general man in realizing the exact pathology and his delay in sending them in. It is often unjust. They do their share and it is more perhaps than it ought to be. A mortality rate in a hospital surgeon's experience must be blamed on something or other. Some times it is the catgut. Again the assistants. Then again, the general practitioner.

RATIONAL TREATMENT

Consider too these peculiar incidents. A leading surgeon of national reputation has made use frequently of one of the very oldest general practitioner methods of treating peritonitis to be found. The much despised older method of emptying the uterus of debris is with us again, although modified. I heard Dr. Schamberg of Philadelphia relate to a very intelligent audience there would be times when they could resort to the removal of a growth of the breast by the employment of paste as the most expedient method, especially if the patient was located remotely. I was in the audience when a leading pediatrician condemned the elaborate formulae, especially the arithmatical envolvments, and intimated we would some day be back again to milk modified in the simplest manner. There is quite an avoidance now of wholesale incision of furuncles. A rational action has been given for the employment of calomel. Castor oil is still a matter of common usage. Almost all the drugs employed except the barbital group and novocaine are still exhibited as they always were. We have the rays—but sunlight was always well thought of. The vitamines are new employments but then the need of them was not very urgent in other days. Doubtless if we all got back to plain, good food many of th modern surgical operations would not be so commonly needed. We have reversed ourselves in the treatment of tuberculosis—urging rest where once it was exercise, but that treatment is still a blot on our ingenuity. All these illustrate that the old general practitioner ideas still exist as standard in many situations with all classes of men. Now compare these with the tower of Babel like modern exhibitions. Lactic acid is lauded by one pediatrician; condemned by another. There are so many different milk modifications and recommended baby diets that they could not possibly all be right. The treatment for eclampsia are legion, yet each new sedative is put forth energetically showing not any of the current ones were altogether satisfactory. There are about a dozen standard treatments for burns. Ether has been replaced by a score of newer anaesthetics, yet it still lives on. Nitrous oxide gas has replaced it in many situations, yet all gas machines can be found slipping through a little ether now and then. Spinal is just now the fashionable one. I have seen it used extensively on every one but the doctors themselves. The new amytal sodium seems to be a real discovery—and its makers are actually seeking a way for oral administration. Insulin is likewise a real success but its crowning glory awaits its partaking by way of the mouth. All this tedious recital of pharmacology and treatment is offered for

but one reason—to show there is no such thing as a line of demarcation between general practitioners and those who claim to be so superior by the so-called group, specialized and standard methods. All use the same thing. All have had their failures—errors and successes. Likewise there are the poor, fair, average, good, and first class in both.

INFLUENCE OF SURGERY

Looking at the whole thing squarely in the face, I suppose it can be said that it was the advent of surgery that first caused the general practitioner to lose his prestige. Surgery is there to see. Medicine (internal) is not. Some men promptly became surgeons and as there is a lot of Thomas in every citizen he delighted in putting his hand into the wound so to speak and holding up the removed evidence. Surgery is nothing if not dramatic. As it became more complicated it required more skillful actors. Finally the surgeons decided in many cases to do nothing but surgery and specialism was born. Now no one wants to be known as a general surgeon and divided specialism is a fact. In the beginning the public, in the habit of placing itself wholly in the hands of the general practitioner, came to find that he referred them to a surgeon very often for what was to be done and whereas the party of the first part seemed to guess at what was wrong, the party of the second part actually delivered the goods all held up in a napkin to see. Naturally, the party of the first part suffered in the comparison. They began to associate him with the more ordinary episodes like childbirth. They were to live to see the day that was also to be lifted from him too in many circumstances. Next they did a lot of their own diagnosing and consulted the surgeon direct. Whereupon the devotees of surgery began to assume all human ailments, had a surgical means of cure and proceeded to act on the premise. They have never got over it and I have always felt that Dr. Deaver looked upon Heaven as merely a place where no such thing as an internist would be allowed to enter. But most surgeons discovered that surgery would not meet all the requirements, so they gathered about them internists of their own choice, pediatricians of their own decision, and likewise all the others and with the dawn came the foundation or clinic or group as it is all known.

For this very reason it can be assumed that surgery and the surgeons have been directly responsible for a great deal that has happened to the general practitioner. Go into any city in the United States and you will find one or more surgeons who occupy somewhat the same positions as the rajahs in India. Their names are household words; their influence is immense. They dominate the field. They could have a mortality rate of ten percent and their personality and prestige would protect them. Of course they do not because they are skillful, courageous, and often brilliant. That is not the question, however. The point is they represent Medicine. It is seldom if ever you find an internist in a similar position, although men like Joslin and Christian come close to it. In some places like Atlantic City a general practitioner may do it. But it is the exception, not the rule. Surgery on up into the American Medical Association manages to be like Al Jolson monopolizing the stage. A good many surgeons will as good as admit all this and admit it was all for the best. They also feel they did not display any evidence of superiority as they quite straightforwardly took command of the scene. But it is probable that in many respects they are quite incorrect about this and the conversion was accompanied by recking little over what they were doing to the general American medical scene. They were causing a good deal of disaster to other men in the other channels of the art of healing. A complete lack of the finer feelings was evidenced in a lot of it. It has been ever thus in human affairs, the victorious clans march triumphantly on, and forget the roads over which they traveled. Had they accomplished all they have brilliantly done with the general practitioner as a comrade on equal terms it is quite probable many of the vexatious problems of the day would not be with us.

Although it was the advent of surgery that began to obscure the general practitioner nevertheless everywhere I go I hear the great

and near great surgeons felicitating the general practitioners on their noble qualities. I think a casual perusal of history will reveal that before any wholesale slaughter was about to take place upon the world's famous battlefields the commanding officer addressed those about to face the rigors of the carnage in most endearing terms. Even the great Napoleon referred with a great show of affection to the armies before him as "MY SOLDIERS". He could afford to—his position was going to be safer. All this sort of thing is a form of flattery that is well received and corresponds beautifully with the striking effects produced by political orators on Memorial Day when they allude to the Star Spangled Banner or on Fourth of July to the sufferings at Valley Forge. Yet it does not get across as it once did, at least not for the preachers, politicians, and service club speakers. Glittering generalities are reserved in other vocations for the ignorant. But there are no signs that it has ever failed yet with medical assemblages. They still gather in large crowds to hear how cautious they must be about altogether trusting to themselves in any but the minor adventures. An analysis of many an address loudly applauded by large conventions of doctors, is in substance a direct warning to them that the matter discussed is too big a contract for them and success will only come to their cases if they are actually released from their control. It always reminds me of the professor in Oklahoma who addressed a crowd of students. He was quite eloquent and at the end of his talk he presented a petition which he read and they all signed. Next day he humorously showed them that they should be more wary next time. They had all elected to be shot at sunrise.

MEDICAL LITERATURE

I have seen the general practitioner led to his doom for over thirty years, not by direct criticism or attack but by surreptitiously teaching him to feel he was inadequate and many procedures too complex for him. How wonderful is man! He rarely weighs much over 250 lbs., yet God is not unmindful of him, neither is Medical Literature which has merely taken his derangements and built up one of the mightiest collections of the printed word the world beholds. On we rush with more every hour and the weight of it must put those trying pictures of Atlas upholding the earth to shame. A quarterly index of it is no slight thing. Services abound whose sole duty it is to skim it over for those willing workers who desire to have twenty or thirty references. He who would cry, "Hold! Stop!" has no more chance of being heard than the lone person in a lynching mob who tries in vain to call attention to the fact it is about to hang the wrong negro. It is a huge Frankenstein monster. There are those who feel they have access to it all. Not so the General Practitioner. He admits he could not have read it much and get anything done. But sometimes he does pick up his Journal and to his consternation finds that Sinclair Peebles, M. D., Solomon Levi, M. D. and Dupont Chevalier Strokalsky, M. D., associated with Emily D. Pinkham, Sam Hill and Brigham Young Snoot working in the Emerald Foundation on more animals than are in "Pigs is Pigs" found that end result after 200 experiments of a dose of calomel such as he had been giving was equal, in co-efficient of two ounces of Magnesium Sulphate, to a half litre of distilled water and nothing more. And while a green stool resulted sometimes where it was exhibited to children this was invariably due to a plate of spinach and the chlorophyl it contained which some parents forced down their progeny under conditions suggestive of a high tension neurosis in the vegetative nervous system.

Medical literature is at once a baffling project. The idea is most prevalent that the greater it is, the more erudite and pretentious we become. The reverse is probably true. Repetition has made it top heavy but like the tower of Pisa it still leans without falling.

As literature has become complex in medicine so has the whole show. The vast tent has become too great a carnival. Too many rings. Too many clowns. Too big a parade. Certain wise showmen have devised separate tents so that the lady on the white horse jumps through the hoops in one, the trained seals are in another, while the acrobats swing elsewhere. The spectator

enters into a beaten track and follows through the gamut of the attractions. But this makes it nothing but a series of side shows in which the identity of the circus is fast becoming lost, to say nothing of people having to look at what they do not care to see. Some day the whole affair will have to either come back simplified to the big tent or be replaced by some other performance. The general practitioner still stands for simplification. As he goes to bed each night such prayers as he utters are for some kindly miracle to descend on his great profession to bathe it in the cool waters of simplicity. Some re-allocation of facts, discoveries, research, diagnosis and treatment that shall ease the fitful fever of complexity in medicine and make it so that to evaluate a patient will not be the vast enterprise it is today. The great weakening factor in the work of a general practitioner is the constant feeling he is possibly overlooking something. He has been taught to think there is nothing really moderate or of passing seriousness. Every case of earache makes him toss in bed lest it be an acute mastoiditis. All epigastric pain he translates into perforated ulcer. Every bump a growing child receives has possibilities for decompression. His case of rheumatism may not be that at all but one where a bone is dying from time to time and maggots should eat it but not for love. He worries because he still has patients with their thyroids and whose basal metabolism is still unread. Many with a full set of teeth. Men who have never been cystoscoped. Women with a uterus. Children who still besport with tonsils. Always tramping behind him like a faithful dog is the conviction he may be only half doing things. He fails to remember that there are a legion of men and women in his community whom he has actually kept from ever being seriously ill at all, simply by "doctoring" their acute infections with judgment and despatch. It is, of course, the usual practice for the followers of Preventive Medicine to claim all this credit. For a greater part of it, however, the general practitioner is responsible except, of course, in time of epidemic. Even then it is the support he gives the health department that makes it possible for them to carry through so well.

It is quite true general practitioners never seem to amount to much in medical meetings and in literature because all they can say is "I saw" or "I felt" or "I think". They are short on tables, plates, statistics and vivisection. I recently read a year book that purported to give a resume of what had happened in the previous twelve months. While those within its covers had had recourse to all these agencies I must confess the absence of direct conclusion was pronounced and conspicuous. No fumbling backward country doctor could have been more indecisive than were some of the paragraphs within that book, yet it represented scientific progress up to date. Nevertheless it might just as well be admitted that very little attention is paid in medical gatherings to the clinical conclusions of medical practitioners. They are considered to be nebulous and not dependable. A general practitioner is supposed to be present to learn, not give out wisdom. He knows this only too well and therefore seldom has the courage to arise and give his views. This merely contributes one more factor in his extinction simply because the new recruits and the internes seeing all, make up their minds to avoid the predicament. The "up and doing" young man craves no such modest niche in the sun.

So there are many localities even in the cities that have not the benefit of a general practitioner. The kind of men who deliberately seek a second or third rate station in their profession after spending six or eight years in acquiring a knowledge of it are becoming less and less each year. I have watched internes for a long while. They seek a contract practice to help pay back their indebtedness and then they hope to become a specialist of some kind. Everything considered, who can blame them? Yet it means the gradual extinction of the general practitioner unless that personage is given the station of respect he deserves. The great loss to the profession of medicine which the gradual reduction in the number of general men means has not become apparent yet, but when it does then you can watch

(Continued on page 138)

PRESS SERVICE OF STATE MEDICAL SOCIETY

No serum does so much for public health as printer's ink

"SITITIS"

Madison, Wis., Dec. 10.—A new disease is gradually attacking the average American. For want of a better name, it is called "sititis." It is caused from people sitting around too much and taking no exercise. It will result ultimately in physical degeneracy of the race, according to the Educational Committee of the Wisconsin Medical Society in a bulletin issued today.

"The average American men, women, and children, should shake themselves free from the menace of sititis," declares the bulletin of the Medical Society. "It is unlike the hookworm in that it is neither a parasitic or constitutional disease. The basis of the remedy for sititis is exercise.

"People sit at the radio, theater and the automobile wheel, and the very ones who need exercise most sit at the games and cheer those who need it least.

"America has become a nation of spectators, who pay big money for the development of physical giants. Adult America is dying between the neck and the waist line from diseases that come not from without, but from within, and attack the four vital organs—the heart, the lungs, the kidneys and the liver. Physical degeneracy is becoming an increasingly important problem.

"For this reason it is vitally necessary that physical education be taught in the schools. One educator even went so far as to suggest that physical tests be made a prerequisite of graduation in schools. But the average educator still thinks that education is composed of training in the three R's. Physical education does not mean the development of acrobats or the swinging of dumbbells, nor does it mean the development of great physical strength. It means rather that the youth of the land be taught again the sanity of the old expression, 'A sound mind in a sound body.'

"In several states, counties, and cities, attempts are being made to have every school child before he enters the first grade have a complete health examination. It is felt that it is the birthright of every child to be physically prepared at the start of his school life.

"'A sound mind in a sound body' should be the slogan for every school."

* * *

A HEALTH AUDIT

Madison, Wis., Dec. 31.—Never was there more health in store for the people of this country than in the new year which is now opening, if they would but guard against disease. The dangers of disease may be obviated in the coming year by proper precautions, according to the educational committee of the State Medical Society of Wisconsin in a bulletin issued today. Balance and check up the health accounts of your body as you do the book accounts of your business is the remedy.

"Consider, for instance, the findings in a survey of 10,000 industrial employees, supposedly well, who were called from their work, one by one, and examined with a view to the offering of any hygienic counsel that might increase their efficiency," continues the bulletin in reviewing a recent survey. "Among these 10,000 there was not a single person who could be rated in Class I; that is, free from physical defects or impairment which could be benefited by some modification of their living habits. In 86 out of every 100, some abnormality was found which, if neglected, would have affected health or length of life. Marked impairment was found in nine per cent, and serious conditions urgently demanding attention in five per cent.

"Even more startling were the results in a group of 100 policy-holders in one of the life insurance companies, startling because all these individuals had at some previous time passed a medical examination. Minor defects requiring attention were found in 12 of the 100; moderate impairments, which would have eventually influenced length of life, in 70; advanced physical impairments which required systematic medical or surgical attention in 15, and 3 presented serious physical conditions demanding immediate medical or surgical help.

"Good health is our basic and our greatest asset in life. With it we may overcome almost any adversity. It is not that we are consciously striving to be "perfect specimens," but that we should endeavor to eliminate the little difficulties which may become big handicaps to our continued well-being in such a short time."

* * *

BIRTHMARKS

Madison, Wis., Jan. 7.—Birthmarks have nothing to do with pre-natal events in the mother of the child. Recent scientific studies show stories to the contrary are but fairy tales.

The Educational Committee of the State Medical Society of Wisconsin today said there was as much basis "for the existence of ghosts and goblins as there is that a mother translates some scare before birth to her child."

"Mothers-to-be need not be worried for fear their babies will be 'marked' no matter what repulsive object may frighten them," continues the bulletin. "There is still a widespread notion that infants whose mothers have been frightened or injured will bear hideous birthmarks as a result. But the doctors who prepared the 71-page booklet of the government point out that there is no connection between the nervous system of the mother and of the unborn baby and such 'maternal impressions' are absolutely impossible.

"The only way a mother may harm her baby, the booklet goes on to say, is by failing to plan her own physical and mental life in a way that will result in the highest degree of health and happiness for herself and therefore for the child. Nervousness and fears may affect her ability to nurse her baby. Steady nerves and mental poise will help her to do so. One fact which the booklet emphasizes is that having a child is frequently a pathway to better health for the mother.

"Health authorities declare that more can be done to lower the death rate of mothers and infants during the period before the baby comes, than at any other time. It is then that the mother should make frequent visits to her family physician to protect her own well-being and to give the baby the opportunity that it deserves."

* * *

MENTAL DISEASES

Madison, Wis., Jan. 14.—Some day the public will have more tolerance to a person suffering from mental disease than it now has.

"Everyone expects to be afflicted with physical disease, but most people like to think that mental disease is for some one else and that they are immune," declares the educational committee of the

(Continued on page 136)

THE JOURNAL BOOK SHELF

Nervous Indigestion. By Walter C. Alvarez, M. D., associate professor of medicine, University of Minnesota (The Mayo Foundation). Price $3.75. Paul B. Hoeber, Inc., New York.

Obstetrics For Nurses. By Charles B. Reed, M. D., F. A. C. S., professor of obstetrics, Northwestern University Medical School; chief obstetrician Wesley Memorial Hospital, Chicago, and Charlotte L. Gregory, M. D., adjunct in obstetrics at Wesley Memorial Hospital; clinical assistant in obstetrics at Northwestern University Medical School. 144 illustrations including two color plates. Third edition. Price $3.00 C. V. Mosby Co., St. Louis.

Minor Surgery and Bandaging. By Gwynne Williams, M. S., surgeon. University College Hospital, 20th Edition, 262 illustrations. Price $3.50. F. A. Davis Company, Philadelphia.

Applied Electrocardiography. By Aaron E. Parsonnet, M. D., F. A. C. P. and Albert S. Hyman, A. B., F. A. C. P. With 102 illustrations. The Macmillan Company, 60 Fifth Ave., New York City.

Primer on Fractures. Prepared by the cooperative committee on fractures, under auspices of section on surgery, general and abdominal, and section on orthopedic surgery in cooperation with department exhibit of the American Medical Association. Price $1.00 American Medical Association, 535 N. Dearborn St. Chicago.

Practical Massage and Corrective Exercises with Applied Anatomy. By Hartvig Nissen, superintendent of hospital clinics in massage and medical gymnastics. Fifth edition, revised and enlarged by Harry Nissen, president, Posse-Nissen School of Physical Education, Boston, Mass. Illustrated with 72 original half-tone and line engravings. Price $2.50 net. F. A. Davis Company, Philadelphia.

BOOKS RECEIVED FOR REVIEW

How It Happened. By Adalbert G. Bettman, M. D. Price $1.00 net. F. A. Davis Co., Philadelphia.

Recent Advances in the Study of Rheumatism. By Frederic John Poynton, M. D., F. R. C. P. (London). Physician, University College Hospital; senior physician, Hospital for Sick Children, Great Ormond St., and Bernard Schlesinger, M. D., M. R. C. P. (London). Physician to Children's Department, Royal Northern Hospital. 25 Illustrations. Price $3.50 net. P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia.

Nursing Technic. By Mary C. Wheeler, R. N., former superintendent of Illinois Training School for Nurses; and Amalia Metzker, R. N., instructor, St. Luke's Hospital School of Nursing, Racine. Third edition completely revised and reset. J. B. Lippincott Co., Philadelphia.

Abdomino-Pelvic Diagnosis in Women. By Arthur J. Walscheid, M. D., director of obstetrical and gynecological department of Broad Street Hospital; director of obstetrical and gynecological department of Pan American Medical Center and Clinics, New York City. 397 illustrations; one color plate. Price $12.50. C. V. Mosby Co., St. Louis, Mo.

Clinical Allergy Particularly Asthma and Hay Fever. By Francis M. Rackemann, M. D., physician to the Massachusetts General Hospital; instructor in medicine, Harvard Medical School. Price $10.50. The Macmillan Co., 60 Fifth Ave., New York City.

Piersol's Human Anatomy. Including structure and development and practical considerations. 9th edition revised, under the supervision of G. Carl Huber, M. D., Sc. D., professor of anatomy; director of anatomic laboratories and dean of the graduate school, University of Michigan. 1734 illustrations. J. B. Lippincott Co., Philadelphia.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Secretary, Mr. J. G. Crownhart, 119 E. Washington Ave., Madison, Wisconsin. These new books will be loaned for an inspection period only.

The Medical Museum. By S. H. Daukes, M. D., director of the Wellcome Museum of Medical Research. An amplification of a thesis read for the degree of M. D., Cambridge. The Wellcome Foundation Ltd., 33 Gordon St., London.

Hospital superintendents and directors of laboratories will find much of interest and much instructive material in this small, well written and beautifully illustrated monograph. The outstanding feature of the Wellcome Museum is the method of group illustration. This, instead of lesions being classified separately under organ and etiology, they are classified as to disease, and all lesions of one disease shown together. This book should serve as a stimulus to those interested in hospital museums, a field of work sadly neglected in this country. Very good, too, is the chapter giving a list of important references. N. E.

Legal Medicine and Toxicology. By Ralph W. Webster, M. D., published by W. B. Saunders Co., 1930.

There is no need to praise or even to review a book of this caliber. The reviewer is not familiar with a better single volume on this so important subject. The first part of the book is devoted to legal medicine. The latter and major portion of the book is devoted to toxicology. While relatively few physicians are vitally concerned with legal medicine and toxicology, this book is extremely valuable as a handy reference for the determination of poisons and treatment. To those having more contact with

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Canadian Pacific 4 shares Assets $1,339,387,262 Transcontinental system covering 16,000 miles.	**Consolidated Gas** 2 shares Assets $1,171,538,219 New York City's gas and electric company.	**American Can** 1 share Assets $191,335,614 Leading makers of metal containers and can-making machines.	**Eastman Kodak** 1 share Assets $163,467,508 Largest maker photographic supplies. Pioneer in new fields.	**Texas Corporation** 2 shares Assets $609,853,084 Outstanding independent oil company. Fifth largest.
New York Central 1 share Assets $1,797,170,084 Famous for its Twentieth Century Limited trains.	**North American** 1 share Assets $807,498,339 One of the largest groups of electric power utilities.	**American Smelting** 2 shares Assets $244,663,846 Mining, smelting, and refining of non-ferrous metals.	**General Electric** 3 shares Assets $491,657,017 Foremost maker of electrical equipment and appliances.	**Union Carbide** 1 share Assets $353,627,096 A great aggregation of chemical-producing companies.
Union Pacific 1 share Assets $1,195,687,913 First transcontinental railroad; a mammoth system.	**Pacific Gas** 2 shares Assets $454,021,922 Dominates the gas and electric business on Pacific Coast.	**American Tobacco "B"** 2 shares Assets $275,320,027 Controls one-third of cigarette and tobacco business.	**International Harvester** 2 shares Assets $384,078,322 Has revolutionized agriculture throughout the world.	**U. S. Steel** 2 shares Assets $2,396,066,088 World's premier industrial enterprise. Most basic industry.
American T. & T. 1 share Assets $2,844,633,099 World's largest corporation; dominates phone industry.	**United Gas Imp.** 4 shares Assets $802,070,454 An outstanding public utility corporation.	**Borden Company** 2 shares Assets $183,960,741 Greatest dairy products corporation, leading in its field.	**National Biscuit** 2 shares Assets $133,224,842 Largest producer in its field Distributes the world over.	**Westinghouse Electric** 1 share Assets $253,928,337 Second largest maker of electrical equipment

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legal medicine, the book may indeed be said to be indispensable. N. E.

Blood and Urine Chemistry. By R. B. H. Gradwohl, M. D., director of the Gradwohl Laboratories, St. Louis and Ida E. Gradwohl, A. B., instructor in the Gradwohl School of Laboratory Technic, St. Louis. With 117 illustrations and 4 color plates. Price $10.00. C. V. Mosby Company, St. Louis, 1928.

General practitioners whose interest in the development of laboratory medicine has been increasing will find considerable satisfaction in this book. There is much in it that is repetition, but this is not without value, particularly to those working in a laboratory. The book is devoted entirely to blood and urine chemistry, with an additional section on the interpretation of blood chemical findings, and a final chapter on basal metabolism. The book is well printed, well indexed, and the directions for the various procedures are given completely and concisely. A reasonably satisfactory list of references is found in almost every chapter. N. E.

Episcopal Hospital Reports. Volume VI, commemorating the 75th year of the Hospital of the Protestant Episcopal Church in Philadelphia. Press of Wm. J. Doran, Philadelphia, 1930.

Volume VI covers the collected papers of members of the staff of the Protestant Episcopal Hospital of Philadelphia from 1921–1930, with a few interesting commentaries on the advancement of medicine and surgery during the 75 years of the hospital's existence.

Most of the articles have appeared in medical journals. There are no new articles especially noteworthy with the possible exception of an accurate record of vasomotor and pilomotor manifestations in spinal cord lesions.

The excellent articles on the results of intracranial section of the glossopharyngeus and vagus nerves and fractures of the leg bones involving the ankles, published in 1927 and 1922 respectively, are incorporated in the collection.

The book gives a good resume of the type of work being done by the staff of the hospital. F. R.

Outline in Obstetrics for Nurses. By F. W. Rice, M. D., instructor in obstetrics, Iowa Methodist Hospital and Broadlawns General Hospital, Des Moines. Price $2.00. C. V. Mosby Co., St. Louis.

This outline is a very useful one for the nurse to follow during her course in obstetrics and also is of value to the instructor as an outline from which to conduct a series of obstetrical lectures.

Nevertheless, the nurse should have at her disposal a standard text in obstetrics in order to enlarge on the various points which are stressed in this outline.

In other words this outline is not suitable for a text from which a nurse can study obstetrics, but rather it should be supplemented by lectures and reading.

This outline gives a concise presentation of facts useful to the nurse, the medical student and even the physician. A. H. L.

Hemorrhoids, The Injection Treatment and Pruritus Ani. By Lawrence Goldbacher, M. D., Philadelphia. Illustrated with 31 half-tone and line engravings. Price $3.50, net. F. A. Davis Company, Philadelphia, Pa.

Like other books on this subject Dr. Goldbacher describes what he terms the best solution and best technique for the injection method of treating hemorrhoids. Contraindications as described in this book leaves a very narrow application for its use. Offers nothing better than surgery.

The treatise on pruritus is interesting and deserves attention. Experience and time will be necessary to determine if the procedure is more effective than those already quite popularly known among the profession. A. W. J.

Injection Treatment of Internal Hemorrhoids. By Marion C. Pruitt, M. D., associate in surgery, medical department, Emory University. Illustrated. Price $3.00. C. V. Mosby Company, St. Louis, 1929.

The injection treatment of hemorrhoids as described by Pruitt requires special technique and skill, and on his own admission the solutions used are not definitely standardized, each operator preferring his own. Contra-indications as admitted by Pruitt, include practically ninety per cent of all cases presenting themselves to the average rectal surgeon. Consequently can see no reason why a good rectal surgeon getting excellent permanent results should attempt perfecting and equiping himself to use the injection method. This book is concisely written, and quite descriptive, which makes it interesting reading. I agree with Pruitt that the injection method can only be used in the hands of very experienced men. A. W. J.

Handbook of Anatomy. By James K. Young, M. D., F. A. C. S. Revised by George W. Miller, M. D., F. A. C. S. Seventh Revised Edition. With 154 Engravings. Philadelphia, F. A. Davis Company. 1930.

This "Handbook of Anatomy" has reached its seventh revised edition. Its purpose has been to lighten the labor of the student of medicine in the field of gross anatomy. This will always be a difficult task for any author to accomplish. The latinized form of the Basle Nomenclature has been used in the text, plates and index. Where both the new and old terms are used, the new is emphasized by its primary position. It is printed in clear, good sized type, with conspicuous headings. The book is bound in a flexible cover consisting of 460 pages and is definitely an improvement over the ordinary quiz-compend. E. J. C.

Burns. Types, Pathology and Management. By George T. Pack, B. S., M. D., fellow of the Memorial Hospital, New York City; formerly professor of pathology and lecturer in minor surgery, The School of Medicine, University of Alabama; and A. Hobson Davis, B. S., M. D., instructor in pathology, University of Alabama. 60 illustrations. J. B. Lippincott Company, Philadelphia and London.

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The authors attribute the fact that they have had extensive experience with burns to the horror and dislike of their colleagues for the treatment of severe burns and scalds. Their general helplessness in relieving these patients actuated them in making an intensive study of the subject.

In preparing their book they have given not only their personal experiences but have made a free analysis of the work of other contributors.

The volume is divided into three parts; Part I. Fundamental Facts Concerning Burns, and Scalds. Part II. Management of Thermal Burns. Part III. Regional burns and burns by specific agents such as electricity, lightning, roentgen rays, radium, the sun, caustic chemicals and war gases.

The book is of importance in that it presents an up-to-date review of the literature on burns at a time when there is a renewal of interest in the subject. Appended to each chapter is a fairly complete list of references. S. J. S.

Tropical Medicine in the United States. By Alfred C. Reed, M. D., Professor of Tropical Medicine, The Pacific Institute of Tropical Medicine within the George Williams Hooper Foundation for Medical Research of the University of California. J. B. Lippincott Company, Philadelphia.

In recent years the nation-wide travel by automobile, airplane and otherwise has caused the increasing appearance in northern latitudes of diseases normally limited to southern areas. A new emphasis is thus placed upon tropical medicine.

Dr. Reed has prepared a very handy and quite comprehensive manual, which is delightful to read and highly instructive. It would be necessary to peruse many volumes in order to acquire the information elsewhere that he has so handily supplied in his book.

With all its excellence it seems unfortunate that the work does not mention such an important matter as the use of the arsphenamines in malaria. The statement that oil of chenopodium is not as satisfactory as carbon tetrachloride in the treatment of round worms also strikes one who used both for years in intensive tropical practice as the reverse of the real situation. The chapters on heat disease, tropical climatology and personal hygiene in the tropics contain much excellent information.

This book would be a good addition to the library of any physician in any climate. It should be in the hands of every medical person, missionary or other intelligent layman who goes to reside in the tropics. How the reviewer would have appreciated this book when he went as a young practitioner to the tropics several years ago. M. F. N.

Manual of the Diseases of the Eye. For students and general practitioners. By Charles H. May, M. D. Director and visiting surgeon, eye service, Bellevue Hospital, New York, 1916 to 1926. Thirteenth Edition, revised. With 374 original illustrations, including 23 plates and 73 colored figures. Price $4.00 net. William Wood and Company, New York. This edition of May serves its purpose as did its predecessors. The fact that it has gone through thirteen editions shows that there is a definite need in ophthalmic literature for a book of this type. It is, however, a pity that this exists. Its perusal will give one an excellent cultural knowledge of ophthalmology or prepare one to pass an examination, but certainly it would not fit anyone to practice the specialty. However, if it is hoped that the general practitioner who is occasionally forced to take care of an eye may find help in these pages, then such topics as The Diagnosis of Disturbance of Motility and the Use of the Slit Lamp have no place there. F. H. H.

MEDICAL LIBRARY SERVICE

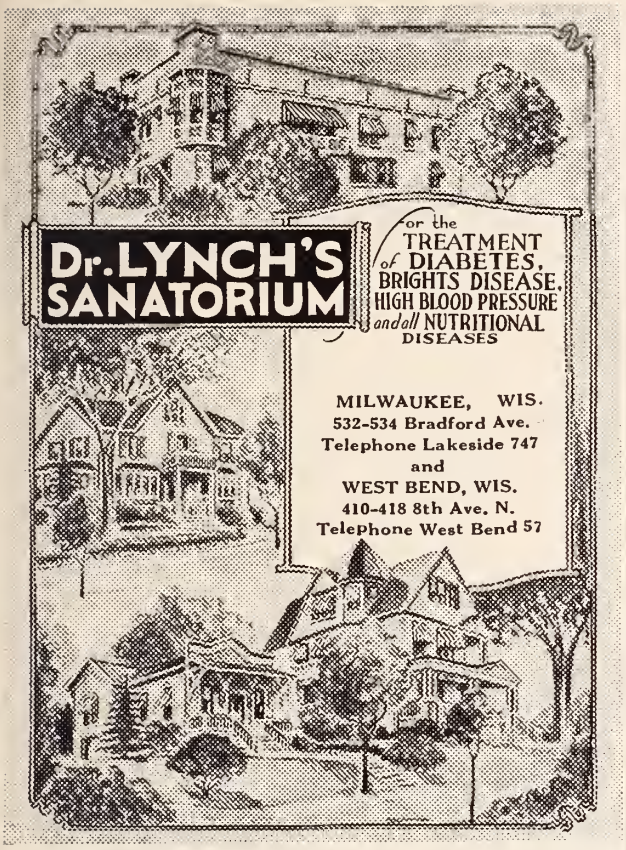
LEISURE READING

What could be more interesting and profitable for a doctor's leisure time reading than the comfortable perusal of medical history or the biography of a fellow professional? The *Annals of Medical History*, now a monthly and on the Medical Library Service list, is the outstanding journal for worthy historical and biographical articles. The *Medical Journal and Record, Medical Life*, and the *New England Journal of Medicine* usually carry at least one such article per issue, and other journals at various times publish similar subjects closely related to their particular specialties or to some particular occasion.

The November 15, and November 29, 1930, numbers of *Le Progrès Médical* contain a French article on Ambroise Paré, the noted barber-surgeon. We also have in the library Stephen Paget's *Ambroise Paré and His Times, 1510-1590,* which is in English.

Then, there are the numerous works on Lister; probably Leeson's *Lister as I Knew Him* is the most popular although the *Joseph Lister Centenary* by Turner is also widely read. When you are in the Service Memorial Institute Building in Madison you might be interested to see the painting of Lister which is to be found on the east wall of the Memorial Room on the first floor. The other painting on the same side of the room is equally interesting as it depicts Pasteur at his microscope. In regard to this latter man of science, his best biography is undoubtedly that written by his son-in-law, Vallery-Radot. Copies of this may be had in either French or English.

If one wishes to glance over the trend of American progress, to mention only a scattered few at this time, there are: *Ephraim McDowell, Father of Ovariotomy* by Schachner; *Life and Letters of Sir William Beaumont* by Meyers; Cushing's *Life of Sir William Osler;* Trudeau's *Autobiography; William Crawford Gorgas, His Life and Work* by M. E. Gorgas; and the many fine articles published in



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celebration of Dr. William H. Welch's birthday. Less strictly American but quite as interesting and stimulating is *The Alabama Student and other Biographical Essays* by Osler.

Of course, all are familiar with Garrison's *History of Medicine*, Hemmeter's *Master Minds in Medicine*, Neuberger's history and similar works. Perhaps Allbutt's *Greek Medicine in Rome*, Campbell's *Arabian Medicine*, Camac's *Epoch Making Contributions to Medicine* or Lambert and Goodwin's *Medical Leaders* are less well known. There is now being published in the Clio Medica series small, primer histories such as that of the *British Isles*, of *Egypt and Assyrian*, and one on *Internal Medicine*. In regard to the specialties, there are such books as: *Surgery 200 Years Ago*, *Selected Readings in the History of Physiology* edited by Fulton, and a *History of Pathology* by Long as well as *Selected Readings in Pathology* by the same author.

All of the above mentioned books and articles, and more in the same vein, may be borrowed through the Medical Library Service. Any requests for material will receive prompt attention. We shall also welcome any suggestions or questions you may have relative to these articles; answers will be given in the column or by letter as you prefer. L. M.

PRESS SERVICE

(Continued from page 129)

State Medical Society of Wisconsin in a bulletin issued today. The bulletin declares that the line which separates the well from those mentally ill is sometimes so close that an accident or disease may cause the temporary crossing of the line. It recommends a more healthy attitude toward those who are afflicted with mental disorders.

"In these days of rapid travel, the old saying that 'there is only a step between us and death' becomes literally true and it is scarcely less true that there is only a step between us and mental disease," continues the bulletin. "A blow on the head, the hardening of the arteries, a severe infectious disease, a prolonged chronic disorder, or unusual physical or mental stress may cause anyone of us to lose his mental balance. Some men and some women also have unusually well adjusted minds. They rarely get angry or excited or agitated or show undue emotion or anxiety at any time. Other fairly well adjusted persons are much more susceptible to environmental factors. If they win at bridge or in the stock market they become jubilant but if they lose, the joy of life is gone and they become despondent. These persons are always up or down and after prolonged hard luck may be in the depths of despair. But there is another type of person who is almost always out of adjustment; to such persons everything is wrong and everybody that does not agree with them is under suspicion. They are jealous, fault-finding and domineering. Another common type of person is one who is adjusted to the ordinary conditions of life but goes to pieces when called upon to face unusual stresses. Such individuals lack courage and mental and physical stamina. There are many other types, some much more resistant to mental disease than others.

"An illustration of the various degrees of resistance to stress was seen in the development of mental disease among the soldiers of the late war. The great majority of our soldiers went to the front and nobly did their allotted tasks. But many cases of mental disease developed among them. Some of the young men broke down on shipboard; others developed mental disorders on the way to the front; others broke down only after strenuous fighting, severe privations, and long exposure to the most horrible scenes of warfare.

"It is probable that each of us has a breaking point mentally. If the stresses, either physical or mental, reach that point we are likely to give way. Such breaks should be looked upon as illnesses, which they are."

* * *

COLDS

Madison, Wis., Jan. 21.—Colds, coughs, sore throat and other troubles of the nose and throat make up a large part of the sickness which interferes with man's comfort and efficiency. If every person with a cold were to use the proper precautions, illness from this source might be reduced fifty per cent, according to the bulletin issued by the Educational Committee of the State Medical Society today.

"To keep free from colds," continues the bulletin, "now that the open season is approaching, observe these simple precautions:

Avoid infection

"Wash hands before eating or handling food.

"Don't shake hands with persons who have a cold unless you wash hands carefully at once.

"Keep away from common drinking cups, roller towels, pipes, pencils and other objects contaminated with fresh secretions.

"Give coughers and sneezers and spray talkers a wide berth. Don't let them aim at your face.

"Keep away from people who say they have the 'flu.'

"Eat only from dishes washed clean in hot soapy water.

Guard yourself against the predisposing causes

"Avoid sudden changes of temperature, close and stuffy air, and fatigue.

"Maintain as high an internal resistance against infectious agents as you can by daily attention to bodily cleanliness, exercise, elimination of waste, rest and diet.

"Suppose you have taken cold, in spite of all precautions; then you become a source of danger to others.

"Be your own policeman.

"Keep clean.

"Cover nose and mouth, with cloth or paper handkerchief when coughing or sneezing.

"Don't shake hands with others.

"Wash hands and face frequently with soap and hot water.

"Stay in bed if possible, or at least away from other people, during the first three days of your cold.

"See to it that your dishes are thoroughly washed with hot water and soap."

COMMITTEE ON MEDICAL EXTENSION

The joint committee on medical extension met in the office of Dean Chester D. Snell, Extension Division, University of Wisconsin, at two-thirty p. m., Tuesday, January 13th. Present: Dean Snell; Mr. Allen of the Extension Division; Mr. Connors, medical field representative; Dr. Joseph S. Evans of the University; Dr. R. C. Buerki of the Univerversity; Dr. Elmer Sevringhaus of the University; Dr. C. R. Bardeen, dean of the Medical School;

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POSITION WANTED — AS OFFICE ASSISTANT —Widow of physician, experienced as office assistant desires position in state. Now residing in Madison but will go elsewhere. Address No. 820 in care of The Journal. DJF

(Continued on page 139)

Dr. Gunnar Gundersen, La Crosse; Dr. Otho Fiedler, Sheboygan; Dr. J. F. Wilkinson, Oconomowoc, and Mr. George Crownhart, secretary of the State Society.

1. The purpose of the committee meeting was outlined by Dean Snell as one called to plan the program of Extension work for the summer. A general discussion followed lasting an hour in which all present participated. At the end of the discussion the following motions were unanimously adopted:

(a) It was moved by Drs. Wilkinson-Evans that the field work for the year consist of one postgraduate course to be given in six centers and that in lieu of two other such courses there be substituted six one-day centers on the subject of insulin and diabetes. Carried.

(b) It was moved by Drs. Bardeen-Fiedler that the postgraduate course for the summer be one on the subject of obstetrics and medical gynecology to be given in the north-eastern district of the state with centers at Appleton, Green Bay, Manitowoc, Marinette, Oshkosh and Sheboygan; and that Dr. Otto H. Schwartz, professor of obstetrics and gynecology at Washington University, St. Louis, and Dr. E. D. Plass, professor of obstetrics and gynecology at University of Iowa be engaged as the instructors for this course. Carried.

(c) It was moved by Drs. Fiedler-Wilkinson that the plans outlined by Dr. Sevringhaus for the six diabetic, insulin centers be adopted; that the centers for this one-day course be Wausau, Madison, La Crosse, Eau Claire, Milwaukee and Oshkosh; that the charge be $5.00 to include a specially prepared pamphlet; that the instructors be Doctors McKittrick of Boston, Wilder of Chicago, Sevringhaus of Madison and a dietitian; and that the course be one of approximately five hours together with a lecture for the lay public in the evening on the subject of diet fads and diabetes. Carried.

(d) It was moved by Drs. Evans-Gundersen that the courses in internal medicine and pediatrics regularly scheduled for this summer be postponed and that the seven-year program be revised accordingly. Carried.

Adjournment was taken at four p. m.

J. G. CROWNHART,
Secretary.

The General Practitioner

(Continued from page 128)

for a radical upheaval. If all surgeons, internists and specialists realized this I feel they would effect a renaissance of that personage, but I fear they will not and therefore must go on and be punished.

THE LAYMAN

The layman when acutely ill in many places must go to a hospital direct. How does he know what he is getting into? In a recent article in Colliers it was suggested he look up those vouched for by The American College of Surgeons. This is more evidence that the surgeons feel competent to do all the directing as to the care of the ill. Notwithstanding their past excellent record, gestures of this sort are highly impertinent. At present the College of Surgeons elects to lay down how all hospitals should be conducted. It is not their work at all but that of The American Medical Association. That this great organization allowed the College to begin the practice is a direct reflection on its strength and gives ample evidence it is really controlled by surgeons. All this has given the laity the idea a hospital is a surgical work-shop, whereas all the hospitalization is a laundry and the men and women merely apparel. Whatever the stain or whatever the mending there it stands to perform its duty—of sending back the garment cleansed and renewed. Whether it be a coryza, a call for hysterectomy or a harrassed woman without benefit of birth control, and ten children—it will meet the occasion. Fees, charges and accommodations must come to where a hospital will literally be a "guest house of the ill". As it is a great many people enter as a last resort, resigned to having something incised or removed. We must not forget that if Medicine is to live Surgery is doomed and if it still exists (the traumatic excepted) in fifty years, then progress has been asleep.

"F. C. G. P."

If the surgeons persist in the practice of asserting control of all good hospitals and giving to the entire medical scene their coloring and there are sufficient general men left I would imagine an American College of General Practitioners will come into being.

The practice of slowly eliminating general men from hospital staffs has advanced pretty far as it is and closed institutions abound

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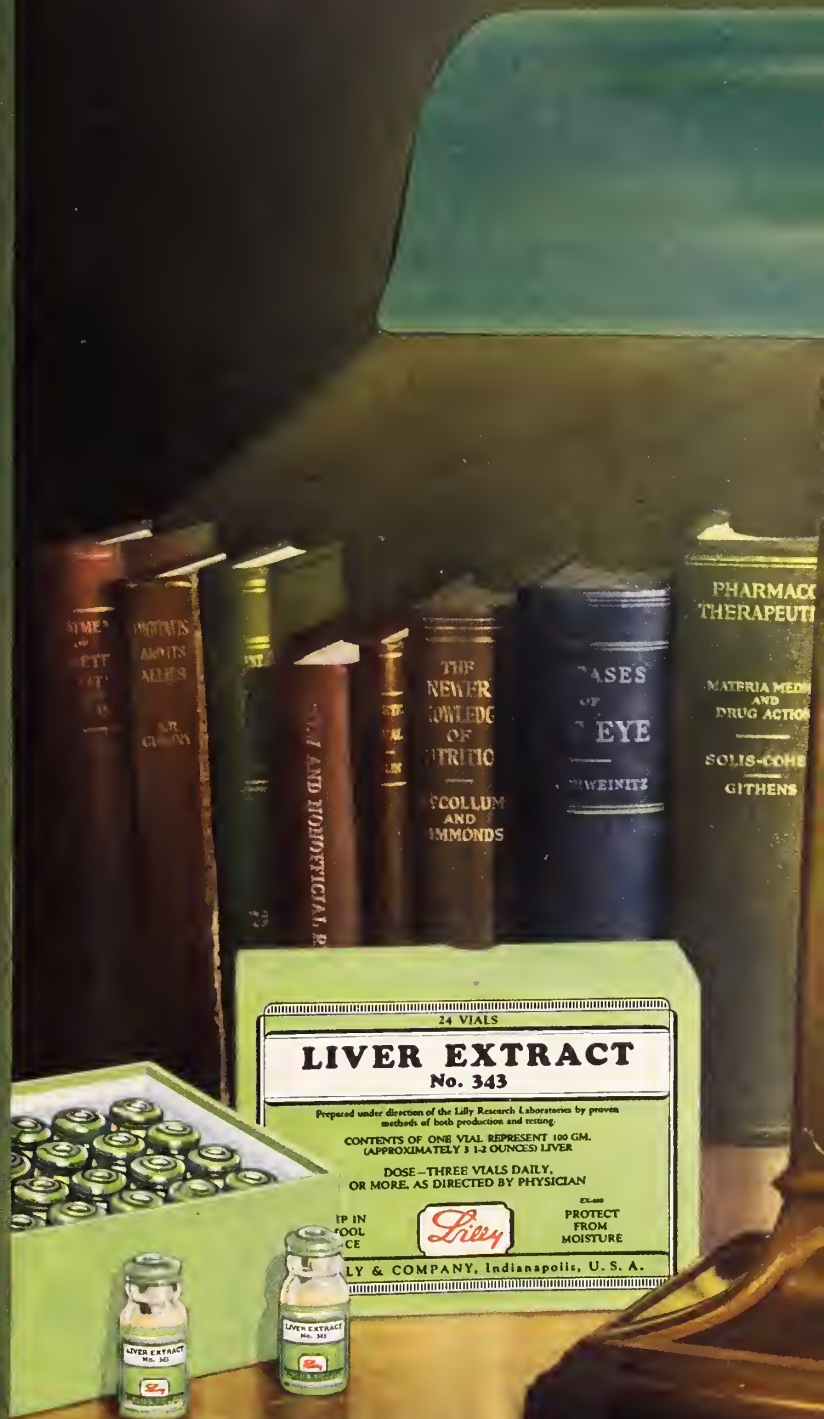

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POSITION WANTED—Graduate registered nurse desires position in physician's office. Three years' experience. Address No. 824 in care of The Journal. F

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everywhere. This can only result in the extinction of general men as a medical factor of any importance. They come very close to being like an employment agency as it is, merely referring somebody to the right place to go.

There are other situations for a College of General Practitioners to look into whose activities now thwart him. As, for instance, lay organizations who pretend to aid, advise and help him but which often usurp his occupations. Those citadels of prophylaxis—the insurance companies only too often try to instruct him or his patients in his absence what their interests are. Another is the medical referee ensconced in a high place in a big corporation from which dizzy heights he assumes, often without justification, a judicial attitude toward the general practitioner. Then that pretentious enterprise which has changed its name like the undertaker did to mortician from "Contract Practice" to Industrial Medcine and which buys and sells medical attention with a profit to itself in some places and which always abrogates in an un-American way the right of a man to pick his own doctor.

There is the split fee. Of course it takes two to make a bargain and just now in New York City an argument rages as to whether the giver of a bribe is more guilty than he who receives it. It makes little difference. It is and always has been solely a moral question. The general practitioner who accepts a fee from a surgeon is in the same class as a waiter who receives a tip. It is not a crime perhaps but it is degrading. To diagnose a case and overcome the natural reluctance for operation, to arrange all the details of transport, and bring the incident up to where it is an acceptable one to a second agent is worth a fee commensurate with each particular occasion. It is an affair between patient and the general man. The surgeon has no reason for knowing what it is for it is a matter of private book-keeping.

They aim to curtail the practice by bringing the split fee into the open. Those who have been surreptitious in the past will be so in the future. There is always a way. No one has effectually stopped or even mitigated the tipping system anywhere. The general man who receives a just fee has no reason to expose to any one what it is. It was given to him by the patient as a retainer fee is extended to a lawyer and quite irrespective of the outcome. His motto should be, "No one but the patient, God and I knows what's in my pocket."

The general man should avoid monotony which happens to be a curse to the specialists. All things have a mill stone strung about their necks. So the specialist has monotony. It is a hard and fast rule in life that if you do a thing over and over your intelligence suffers atrophy, your vision is blurred to many other things, and you become either phlegmatically resigned or nervously hyper-critical. Following this either you have a tendency to grow careless or are filled with ennui. It is unavoidable and rather regrettable. That is why a girl working day after day at an unguarded press ultimately gets one of her fingers taken off. Confining yourself to one thing eventually "gets" you. To assume therefore that just because one is educated and the other is not there will be quite a difference by monotony working on the mind of an ultra specialist who confines his ambitions solely to taking out hundreds of tonsils by the Sluder method and he who sticks pigs day after day at Armours is fallacious.

There is too much law in the United States these days but not enough in medicine. Activity is unrestrained. A reliance is placed in some quarters on an adaptation of The Golden Rule. It works very well considering but does not curb the wayward. A large part of the present chaotic conditions in Medicine today are entirely due to a lack of codified law.

Research has not been the help to the general man it should. Considering its great endowments, its wealth, its immense corps of workers, it would seem as if the mountain has given forth a mouse as to clear cut, helpful advice to the general practitioner. The general man still has to depend to a great extent on empirical facts he has learned by contact. Unfortunately, he receives all the criticism while research is being continually lauded. It is rather a sad commentary but the general man has had some greater help scientifically from some of the manufactur-

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Upon request, of any physician, the Sanitarium will be pleased to send the details of its service and rates.

SAINT PAUL
MINNESOTA

ing chemists than he has the pretentious research bureaus.

So this man—the general practitioner—is just now an outcast from the medical Eden. He is in a sort of "Paradise Lost" if it is not straining on the word "paradise". To catalogue him just now would involve a look into that startling phantasmagoria of ethical values that has dissolved a hundred customs of yesterday into the apparent obsolete of today. Yet a voice still calls, "It is not for the best".

THE PENDULUM

Is it possible that evolution may not always necessarily mean advancement? Is it tenable to hold that what we seem so naturally to slide into may not always be progress? Are we altogether correct in assuming that all this moving swirling vortex this Machine Age gives us is necessarily the best for us to have? There are many things that would seem to suggest a negative answer to all three questions. It is just as well to recall that all effort and all development would seem to occur in waves and to be measured by their character, their velocity, their momentum and their length. We have the optimum and the minimum. Action equal to reaction. While many are busy declaring this "The Golden Age of Medicine", considering the undisguised perplexities we are having economically which in the end detract from our scientific efficiency, there is nothing to prevent some one from arising and saying this is the very moment when we are in the furrow of the wave of advancement; the tide is out; we are in reaction. We shall come back of course but just now are in retreat. His argument being individualism is at a low ebb. For the disintegrating process that wormed its way into the medical fabric and relegated the general practitioner to a secondary, even tertiary importance exacted its price and despite its modern cut, left the apparel replete with holes. You that like to do that sort of thing can point out the brilliant excellencies of modern medical science, you can exhibit shimmering in the noon day sun the vast lay-outs covering acres. You can boast the quantity, even quality of professional statistics and achievment, but you cannot utter any words that shall enshrine the individual as having become more individualized, nor that versatility is more versatile, nor that the spiritual values have increased in spirit. Whatever he was! Whatever his deficiencies! Whatever he represented! Whatever his lack in scientific glitter! when the General Practitioner was shunted towards oblivion these things went with him. This may all be denied, still I think it is all there for seeing eyes to see.

This I cannot fathom: the human race primitive and ignorant and reaching out for experience and collective reasoning to rapidly give it something for a background came to gather in groups, hordes, crowds and masses. After a history and some knowledge came to its assistance men began to think for themselves. So the individual was born and each man could claim some dignity, even went so far as to establish a connection with his maker. Later all the great things came from single men. Almost never from groups. Civilization spread its wings. Man found that to be captain of his soul was a glorious adventure. It made life tolerable. Government, Religion, and Industry have each in turn sought to interfere with this individualism. They never have. Some way it survived. But today men themselves have caught again the urge that to accomplish anything worth doing they must go back to the original idea of crowds, committees, groups, hordes and commissions. Even the material must be produced en masse. The result has been over-production, idleness, and stagnation. They say we must seek other markets—other places. But it seems they too are super-saturated. What has it all availed? If that is not a retrograde step, what is? If that is not sinking into the furrow, what pray is it? If that is not confessing a single man is not the unit of civilization, what would you call it? Denial that a single brain is efficient? What of Aristotle? Plato? Christ? Shakespeare? Edison? It proclaims that the day is coming when nothing less than ten or twenty cerebrums collectively in action may meet a serious problem amidst the rigors of our strenuous lives. Perhaps it bespeaks the day when Mother Nature will stand by the boiling pot as did the witches in Macbeth and toss in

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some fifty men to simmer out a superman. Medicine began with many men congregating in chaos to dimly see a science in the offing. Bye and bye the general practitioner was evolved and under his guidance Medicine has reached where it is today. Now we are going back amidst some chaos too, where we collect again in groups, crowds and hordes and no one seems to believe we are surrendering a lot in doing so—more than we will ever know.

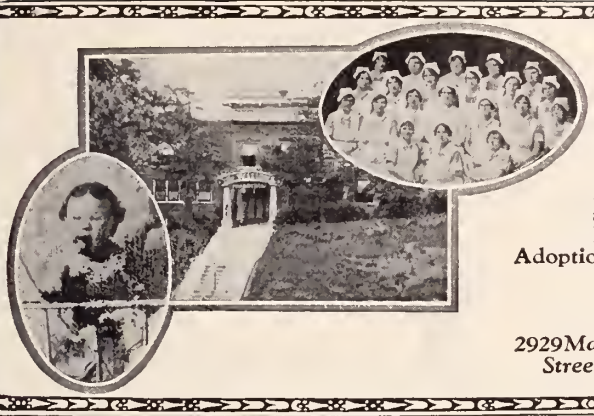
No one has the courage left to do a thing alone. A diagnosis is a product of a conference; a practice of medicine a set of volumes of ten or more written by a hundred contributors. Will the patient have a happier course than if he had a Reisman, a Hoover, or a Deaver? Will the shelf of books be more informing than that old single green volume—Osler? There is still some hope for the future general practitioner but not for us. It is generally conceded we do not make us of all the brain substance that we possess. There are convolutions in our bony crypts that have never known the honor of our occupancy. Therefore some thought should be given to their sub-letting. It may be we shall have to begin with the very young, but what of that? In any event let the future ambitions of the educational life of today be concerned with awakening these dormant coils that like a serpent beseiged by winter, neither toil nor spin. Then when the young man passes that fateful seventeen where all he is going to have in the way of foundation is laid he may enter his medical career confident that the medical school will give immediate cognizance to these erstwhile vacant cerebral cells and pour into their unfathomable depths the necessary and salient features of all the specialties. If reports are true there is enough of this idle grey to embrace them all and have some left over, for some better scores in golf. Then it will not take a dozen men to evaluate a diagnosis but one, assisted by those bright angels of perfection, the nurses and technicians, could make a patient aware of what is wrong with him without being introduced to strangers, or becoming familiar with a whole skyscraper or making a curtailed tour of these United States.

Specialists are a necessity. That is axiomatic. There must be a sane limit, however, to the number who can stand around the bed of an envisaged patient. In the past we have devoted all our time in conference to scientific subjects. None to our economical side, our exploitation by others or what is of pressing importance, the relations of each division of our activities to the other. Had we done this the pituitary gland, metaphorically speaking, of our professional relations would not have developed this surgical or specialized acromegaly. On the other hand, general practitioners should give heed to that section of their cohorts who are backward, slovenly and unprogressive and whose animadversions are used as evidence against them. They should cease to be such undeniable genuflectors despite the fact that aroused genuflectors have made most all of the revolutions and caused the birth of freedom.

CONCLUSION

Medicine cannot go on and will not advance unless every section is given its just dues. The general practitioner must be recognized, not as an adjunct but as probably the most important division of Medicine. The surgeon and internist should drop much that they are now doing in other extra professional digressions and make up their minds to re-instate the general practitioner with a determination that shall be conspicuous for its concentration. For if he fails—so ultimately will they.

It would seem then that the very first step in this procedure would be that the general practitioner and the one to whom the case is referred should unite with a very broad visualization to use such steps in the handling of the case that the patient will never lose sight of the undoubted important part the general man has played in its progress. If he is where the case is, he should be in direct touch with it—not as a mere looker-on —but as still in control of it although not interfering with such steps as the surgeon elects. If he is absent—then all depends on the diplomacy of the surgeon or other specialist. Whatever it is, the patient should



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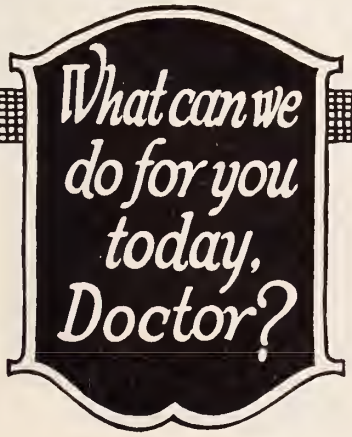

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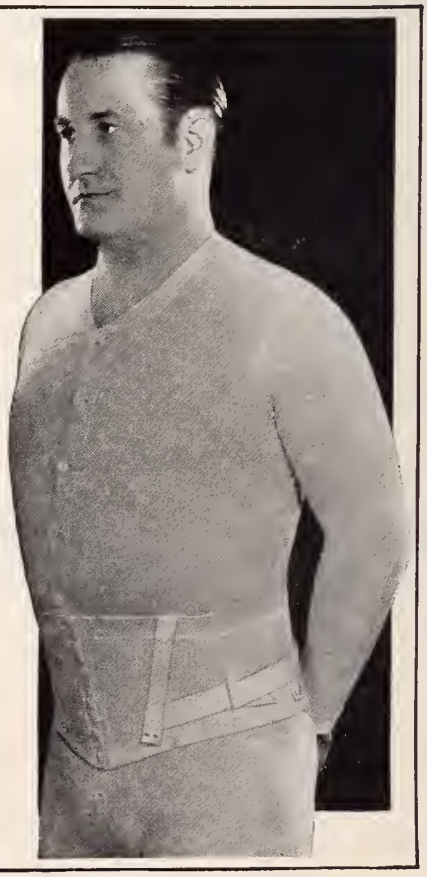

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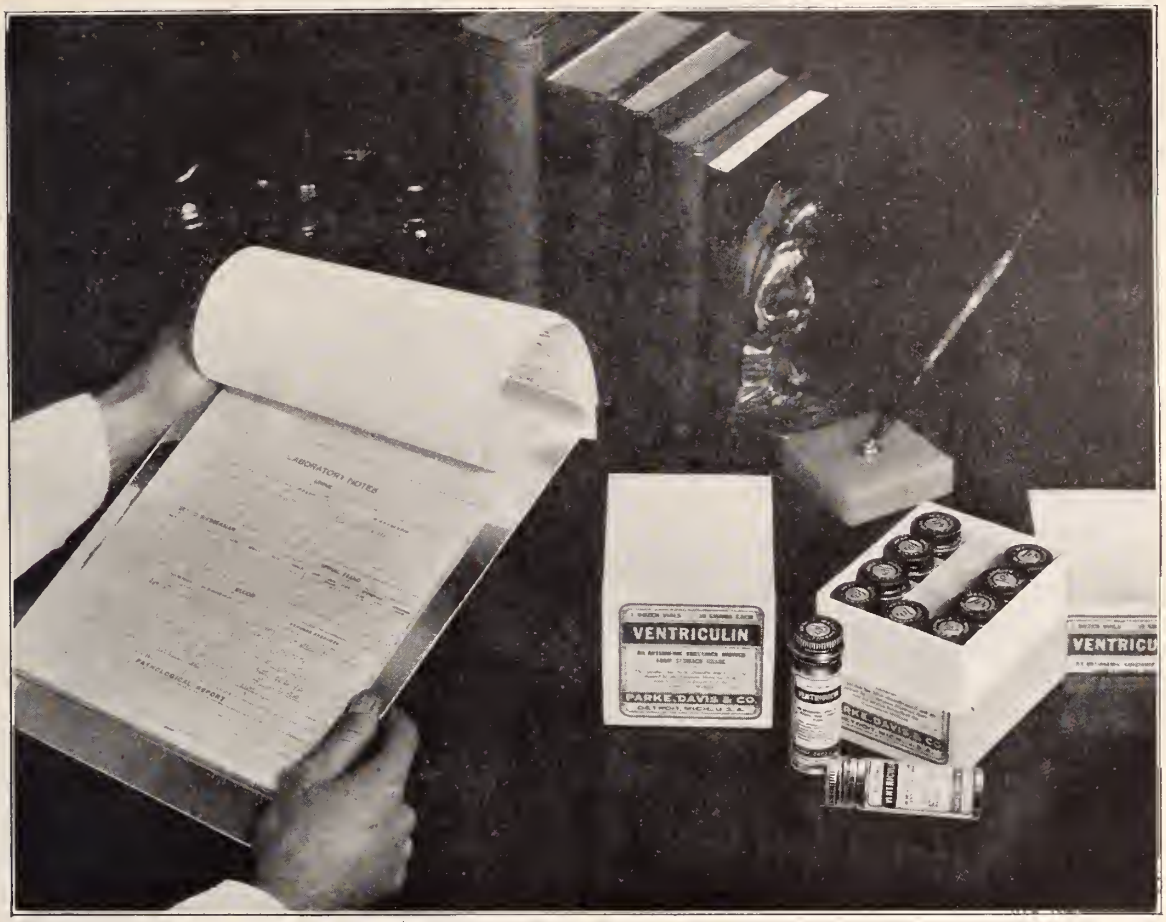

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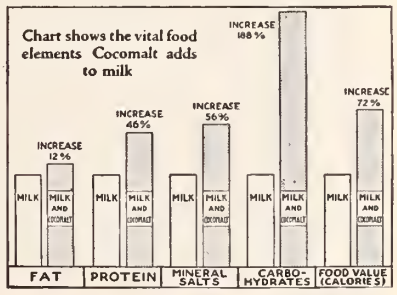

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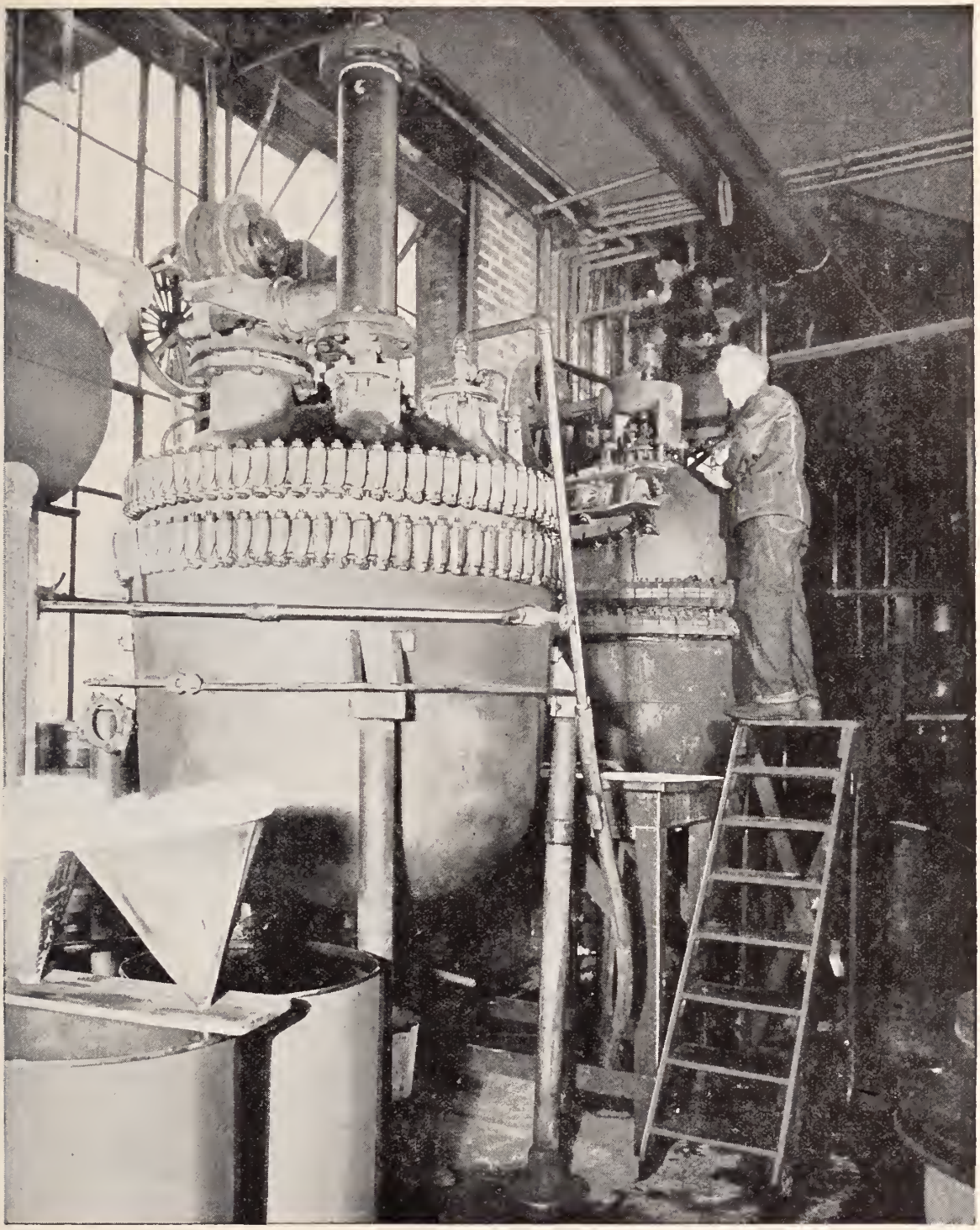

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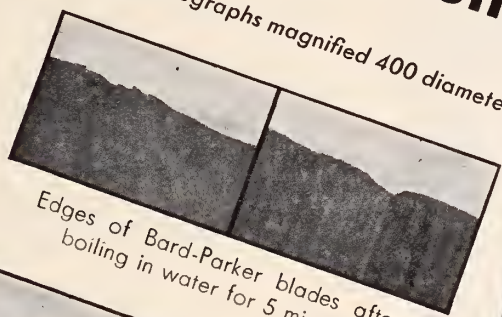

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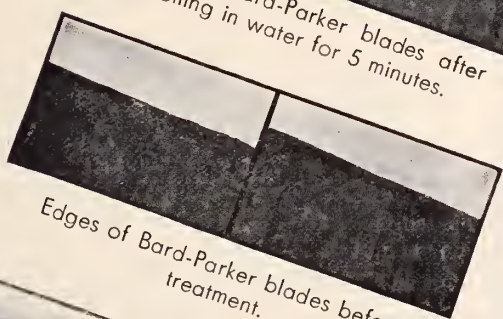

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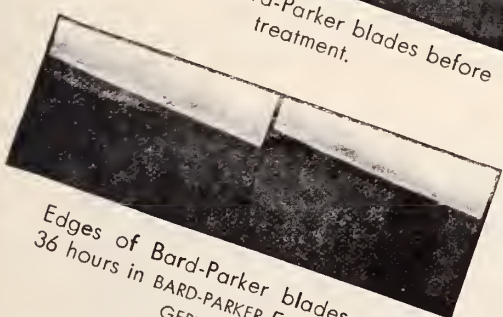

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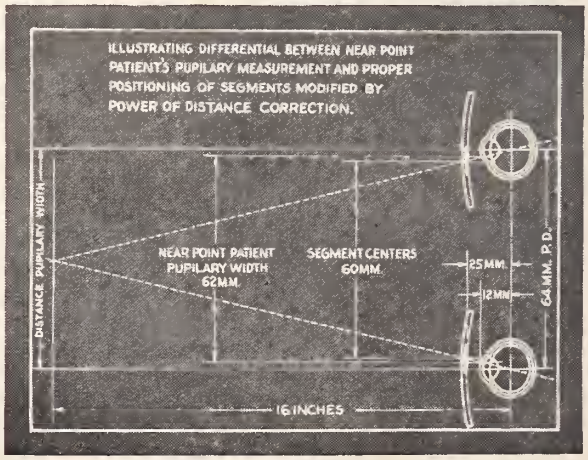

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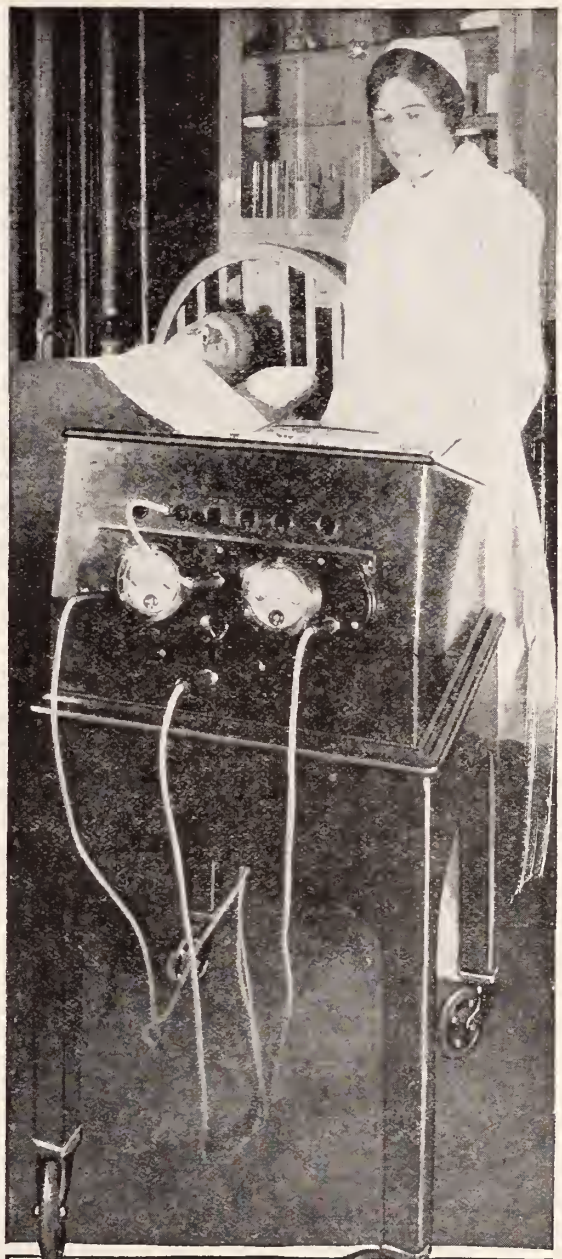

Showing diathermy used for producing therapeutic fever in the treatment of dementia paralytica. Photo courtesy Northwestern University Medical School, Neurological Clinic, Chicago.

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The Wisconsin Medical Journal

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The Prevalence of Unsuspected Disease in Industrial Workers*

By THEODORE L. SQUIER, M. D.
Milwaukee

The present study is based on examinations of 2277 adult males during the five-year period from March, 1925, to March, 1930. The minimum routine in each examination was a comprehensive medical history, physical examination with the subject stripped, x-ray of the chest, electrocardiogram, urinalysis, blood count with differential, blood Wassermann and dental examination with a full mouth dental x-ray. Special x-ray and other studies were made as indicated. It is believed that this group is fairly representative of an average industrial body. Examinations were not compulsory, so it can be argued that selection might play a role. However, the confidential relationship between patient and physician has been maintained strictly and consequently fear of loss of employment through the discovery of physical impairments has not kept away those who were sick. The strikingly large number with no complaint is sufficient evidence that the examination was sought by those who felt well.

The average age of the group was approximately thirty-five years. Forty-eight were under twenty years of age, 1674 were between twenty and thirty-nine, while 53 were over sixty. Twelve hundred thirteen were laborers, 614 were foremen or skilled workers, and the remaining 450 included executives, engineers, mechanics and office workers. Sixteen hundred fifty-six were married, 577 single, 23 widowed, and 21 were divorced. A family history of heart disease was given by 109, of cancer by 85 and of tuberculosis by 83. A past history of rheumatic diseases was given by 226, of pleurisy by 115, of venereal disease by 79 and of tuberculosis by 10. Prior to examination 308 (13.5 per cent) had had tonsils removed, 220 (9.6 per cent) had had an appendectomy, 79 had had a herniotomy, 76 had had nasal operations and in 61 unclassified major operations had been performed.

Of the group, 1029 gave the name of a family physician to whom a complete copy of examination findings was sent. Sixty of these physicians advised us of the progress of their patients under treatment. This number is discouragingly low. Better cooperation would be of inestimable aid to us, not only in the estimation of results, but also in securing the elimination of correctable defects in those who need to be urged. Five hundred seventy-one (25.7 per cent) of the group had no complaint at any time while 848 had no complaint when seen last. Digestive complaints present in 272 led in frequency with respiratory complaints in 264, a close second. Two hundred thirty-five complained of pain in the abdomen, 197 of backache and 196 of tiredness.

FOCAL INFECTION

Most of those in the group were individuals in the middle thirties still too young for the degenerative diseases of middle life to have developed. The importance of chronic focal infection in such diseases is more or less problematical. Even the most skeptical clinicians have seen acute nephritis develop after severe tonsillitis, and have seen the glucose tolerance of a diabetic rise after the removal of abscessed teeth. Such evidence is at least suggestive.

Most wage earners who feel well will not consult a doctor. They feel they cannot afford to do so. Preventive medicine, however, is not applicable to the sick. Any success which may come in reducing the appalling waste of life through degenerative disease must come through the early recog-

* From the Department of Preventive Medicine, A. O. Smith Corporation. Presented before the 89th Anniversary Meeting, State Medical Society of Wisconsin, Milwaukee, September, 1930.

nition and elimination of contributing causes before, not after signs of a break can be detected. Save in very recent years, physicians have spent little time in careful studies of supposedly healthy persons. Proper evaluation of the causes and recognition of the pre-clinical signs of degenerative disease can only come when the importance of this phase of medicine is fully recognized. In the meantime detailed records kept with scrupulous care must provide the foundation for future studies. Possible causes of degenerative disease must be eliminated so far as possible on suspicion alone. Those who fail to carry out corrective advice will provide an adequate control group for comparison.

Although in the entire group only 66 complained of trouble with the teeth, periapical disease was the most prevalent single defect and 1192 (52.6 per cent) were found to have definite evidence of infection about the apices of teeth. Those with suspicious or pulpless teeth which appeared normal by x-ray have not been included. This omission is made because we wish to emphasize the prevalence of dental infection in a stage uniformly accepted as significant, not because we feel that the x-ray negative tooth is unimportant. Of the 1192 who had periapical disease, to our knowledge, 62.1 per cent have had all dental infection removed and an additional 5.6 per cent have had partial removal of such infection.

Hypertrophy of the tonsils and chronic tonsillitis was present in 821 (36 per cent) of the group. If those who previously had had a tonsillectomy are eliminated, this incidence is increased to 41.6 per cent. Some individuals had frankly diseased tonsils or gave a history of repeated attacks of sore throat. In many, however, the evidence was considered insufficient with our present knowledge to justify more than observation. Paul D. White goes so far as to advise tonsillectomy routinely in every child or young adult who has had a rheumatic infection or rheumatic heart disease, and in every other young person who has had tonsillar infection or who may be exposed to rheumatic fever or chorea. Perhaps, he says, it is but slight protection but it seems worthwhile. Tonsils that appear harmless so often are found on removal to be filled with pus, that appearance alone cannot be taken as the sole criterion for judgment. A family history of many deaths from degenerative disease, the presence of early signs of vascular hypertension, or other signs of denegerative disease justifies the removal of tonsils that are only suspicious.

Chronic infection in the prostate gland is frequently over-looked in the search for foci of infection. Many physicians have felt that prostatitis, in the absence of a preexisting venereal disease, was extremely rare. No one who has routinely examined the prostate of every male patient can agree with this idea. Palpation of the prostate is of itself not sufficient for a diagnosis. Many prostates which feel perfectly normal are definitely infected. The prostatic secretion must be expressed, and the fresh unstained specimen examined microscopically. Using the presence of ten or more pus cells or clumps of pus cells in a high power field as the basis for diagnosis, chronic prostatitis was found in 499 or 21.9 per cent of our group. Non-obstructing enlargement of the prostate was present in an additional 101 (4.4 per cent), from whom we were unable to express prostatic fluid. None of these men complained of symptoms suggesting prostatic disease. In several, however, a direct etiological relation was established between their prostatitis and some systemic disturbance. This was notably true in iritis. There is a close relationship between chronic prostatitis and focal infection elsewhere in the body. In fact, so long as diseased teeth or tonsils are present, it is almost impossible to clear up a chronic prostatitis. In an individual who previously had had no evidence of infection on several successive examinations, I have seen prostatitis develop after a severe cold.

In the presence of symptoms or physical signs which might be directly referable to focal infection, or in the presence of a family history of degenerative diseases, chronic infection of the prostate should be actively treated. The removal of any other contributing foci which may be present, such as diseased teeth or tonsils, as already

intimated, is of primary importance to success. Until we have diagnostic criteria that will enable us to differentiate between a prostatitis of no significance and one which may be a factor in producing disease, it seems logical to advise treatment in all. In the group where evidence of systemic disease is present treatment should be insistently urged.

Diseased teeth, tonsils and prostates comprise the outstanding triad of foci in this group and probably for men in general. Sinusitis was present in 51, chronic mastoiditis in 16, appendicitis in 134, and gallbladder disease in 21.

PULMONARY TUBERCULOSIS

Tuberculosis of the lung including all stages of activity was diagnosed in 74 of the 2277 men. Subsequently in 8 of these no tuberculosis was found. Fifty-eight were under 40 and all but 4 were under 50 years of age. There were 38 laborers, 25 skilled workers, and the remaining eleven included engineers, office workers, designers and draftsmen. In 15 a family history of contact with tuberculosis was given, while in 59 no contact history was obtained. Four gave a history of previous sanatorium care. One of these, at the time of examination, was found to be moderately advanced active. The others were quiescent or arrested. Three had had a previous diagnosis of tuberculosis, but had not had sanatorium care. One of these was questionably active, one was arrested, and in one no evidence of tuberculosis was found. A history of pleurisy with effusion was given by five. Two of these had active tuberculosis, two were arrested, in one no evidence of tuberculosis was found. It may be emphasized that although in one of the group who had had pleural effusion no tuberculosis was found, it is felt that he still requires frequent observation. Of two who gave a history of hemoptysis, advanced active tuberculosis was found in one, while no tuberculosis was found in the other. There was a past history of pleurisy in twelve, of typhoid in four, cough in two, and night sweats in two. It is of interest that a history of previous pleurisy was obtained in 16 per cent in this group in contrast with 5.5 per cent for the entire group of 2277 men.

Fifteen (20.2 per cent) of the tuberculous group had no complaint as contrasted with 25.7 per cent with no complaint in the entire group. Twelve complained of cough, twelve of pain in the chest, six of hemoptysis, six of tiredness or weakness, five of colds, two of dizziness, two of nervousness, two of pain in the shoulders, one of expectoration, one of catarrh and one of tickle in the throat. Seven complained of pain in the abdomen, five of pain in the back, one of pain in the legs, one of headache, two complained of trouble with the teeth, one with eyes, one of gas, and one of hemorrhoids. Parenchymatous lesions were demonstrable by x-ray in 59 at the time of the first examination and in five more lesions were subsequently demonstrated by x-ray. In 39 impairment of the percussion note was found on examination and in 17 of these rales were present. No impairment could be demonstrated in 19 although one had rales at the apex. Of the five who had positive x-ray findings subsequent to the first examination, two had impairment and rales, one had rales alone, and in two no impairment or rales were found.

A positive sputum was obtained in only sixteen of the group although the tuberculosis was considered active in twenty-five and questionably active in seventeen others. A diagnosis of suspected tuberculosis was made in seventeen and finally confirmed in eight.

At the present time 34 of the tuberculous group are still with us and working. Five who have had sanatorium care are arrested. Three are still in the suspicious class requiring close observation.

Twenty-nine of the tuberculous group are no longer employed. Seven of these had sanatorium care before leaving. Three left because sanatorium care was advised. Two of the tuberculous group are at present absent because of sickness and nine have died. The average time after the first examination until death was fourteen months with a minimum of two months and a maximum of thirty-two months. Only two of those who died were over thirty-five years of age.

It is of some interest that none of those who died gave a family history of tuberculosis and that only four gave a past history of significance. Two had had pleurisy, one had had hemoptysis, and one had previously been in a tuberculous sanatorium. Six of the nine who died had positive sputum. Four of the tuberculous group had a positive blood Wassermann and two of these have died. I wish to present two illustrative cases.

CASE REPORTS

Case One: O. U. A married draftsman, age 34, was seen in March, 1925, complaining of a catarrhal condition in the throat and nose. At 20 he had had pleurisy with effusion and was in bed for two weeks. At 27 he was in Muirdale sanatorium for seven months.

Impairment was found at the left apex in back with increased breath sounds and whispered voice, and there was impairment and diminished breath sounds at the left base. The temperature was normal, the pulse 68, and the blood pressure 122/80. Chest x-ray showed an old fibrous process at the left apex, evidence of old fibrous pleurisy at the left base and a little suggestive haziness in the right apex. The clinical evidence, repeatedly negative sputums and the x-ray appearance all indicated an arrested process.

His progress was uneventful until January, 1927, when he contracted a cold with a productive cough. There was no fever, the pulse was 84, the blood pressure 120/74 and his weight remained unchanged at 151 pounds. Chest examination and x-ray gave little evidence of any important change in his condition, but the productive cough was very significant, and it was also suggestive that his pulse now was 84 in contrast to 68 formerly. In the sputum one to six tubercle bacilli were found in each high power field.

He was despondent, irritable and in every respect a hard patient to handle. After a few days at Muirdale he became intolerant, unruly and refused to stay longer. He tried home care under the supervision of his physician and in July, 1927, it was reported that he was not staying in bed as advised and was rapidly progressing downward. On July 14, 1927, he returned to Muirdale in a cooperative mood and remained until discharged in November, 1927. His cough had disappeared and he felt much better. Medium, inspiratory rales were present in the supra-clavicular fossa on the left, but no other signs of activity were present. Incidentally rales have been present at every subsequent examination.

In May, 1928, he felt that he was well enough to return to work. However, a temperature of 99.2 and a pulse of 102 forbade. Treatment was continued until on January 23, 1929, it was felt safe for him to return. He was permitted four hours of work daily and in May, 1929, his condition was entirely satisfactory. He was then allowed to increase his work to six hours daily, with four hours of work in the morning followed by a rest in bed from lunch time until three in the afternoon and then two hours more of work. He felt so well on this schedule that without permission he increased his work to eight hours daily. In spite of the added load his condition was entirely satisfactory in November, 1929, but in April, 1930, although his pulse was normal and the sputum negative, it was felt that his general condition was not quite so satisfactory, and he was returned to the six hour regime which he is following at the present time.

Case Two: I. N. An engineer, married, age 40, was seen May 24, 1927, complaining of bronchitis. There was no family history of tuberculosis, but in 1912 he had had pleurisy with effusion. Impairment was present at the left apex with bronchial breathing but no rales. His pulse was 64, temperature 98.6, and blood pressure 114/70. Tubercle bacilli were present in the sputum, the blood sedimentation rate was very rapid and chest x-ray showed an old process at the left apex with annular shadows and fuzziness suggesting activity.

He was extremely co-operative and received sanatorium care from May 30, 1927, to November, 1927, with graduated exercise during the last weeks, so that when discharged he was fairly active and felt well. On December 1st he was allowed to return to work for four hours daily. He spent eleven of the 24 hours each day in bed. In March, 1928, a little re-activity following an acute cold necessitated an increase in his rest period, but in a relatively short time he was back on the four-hour schedule again. Since May, 1928, his clinical course has been uneventful. His working hours have gradually been increased so that for over a year he has been working actively full time and feels perfectly well. When last examined, August 4, 1930, no evidence of activity was found and his x-rays showed only a small patch of pulmonary pathology in the left infra-clavicular region, so much reduced that from the x-ray standpoint it was interpreted only as very probably of tuberculous origin.

These cases illustrate three important points. (1) That workers who have quiescent or arrested tuberculosis must be watched very carefully, (2) that home care is a poor substitute for adequate sanatorium treatment and (3) that careful supervision with the hours of work controlled by clinical signs is of very material aid in the re-habilitation of the tuberculous worker.

CHRONIC CARDIAC VALVULAR DISEASE

Chronic cardiac valvular disease was found in twenty-seven or 1.2 per cent of the group of 2277. Twenty-three of the men in

this group were under age 40 and the occupational distribution corresponded approximately to that of the entire group. Fifteen gave a past history of rheumatic fever and three of scarlet fever. Seventeen had no complaint, while two complained of joint pains, two of tiredness, two of dyspnoea, one of mid-epigastric pain, one of pain in the chest, one of palpitation, and one of trouble with the teeth. Tonsils had previously been removed in nine, in seven the tonsils were found to be frankly diseased, questionable in six, and in five they appeared normal. Frank periapical dental disease was present in twelve while six others had non-vital teeth that were regarded with suspicion. In eight the dental examination showed nothing abnormal and, because of acute decompensation at time of examination, no dental study was made in one. Three of the group have died, one at 30 years of active bacterial endocarditis, superimposed on an old mitral stenosis; one at 31, of mitral stenosis with infarction of the lungs and spleen; and one at age 33 of rheumatic aortic insufficiency.

Dr. George Herrmann says in Oxford Medicine, "There is an unfortunate erroneous impression which many physicians retain that all, or practically all aortic disease is of syphilitic origin. This idea of the predominance of the luetic type of aortic disease is gained most probably from experiences in the dead house of charitable institutions. The character of the clientele of a clinic determines, to a large extent, what is to be the commonest etiological factor." Of these 2277 men, we have seen only one with luetic aortic insufficiency. On the other hand, rheumatic aortic insufficiency was present in eight (29.6 per cent) of those with chronic cardiac valvular disease. Five of these gave a frank history of rheumatic fever and the blood Wassermann and Kahn test were negative in all. Only three of the group gave a history of gonorrhoea and none gave a history of syphilis. Left axis deviation was shown electrocardiographically in five. Three showed no axis deviation and the blood pressure of these were 170/84, 170/50, and 132/42 respectively. The average age in this group was 31.1 years. Only one, aged 41, was over 33 years old. A luetic etiology cannot positively be excluded in him for although the blood Wassermann and Kahn were negative, there was no history of rheumatic fever, and his age and history of having had gonorrhoea were both suggestive. The other two who gave a history of gonorrhoea both had had definite attacks of rheumatic fever.

Although in this group it is too late for the prevention of heart disease, much can still be done to prevent the constant recurring infections which lead to ultimate cardiac failure and early death. One case will illustrate this point.

CASE REPORT

R. F. An engineer, age 32, married, was seen first in August, 1925, complaining only of disturbing dreams. He gave a history of having had a severe tonsillitis at the age of 8 and tonsillectomy at 9. At the age of 14 he had rheumatic fever with subsequent attacks recurring at 16, 21, and 25. After his last attack at age 25 he was told that he had heart trouble but was subsequently accepted for service in the navy. He had no cardiac complaints of any kind but had known for the past six years that his blood pressure was somewhat high.

His tonsils were ragged and somewhat reddened. The heart apex was in the fifth inter-costal space in the nipple line and a soft, diastolic murmur was heard at the base of the heart and along the left border of the sternum, down as far as the mitral area. The blood pressure was 140/70. No Duroziez murmur was heard over the femoral. Chest x-ray showed a heart somewhat enlarged to the left with a blunt apex and no evidence of auricular enlargement. There was left axis deviation in the electrocardiogram. Seven teeth were markedly rarefied at the apices and one other non-vital tooth was present which showed no x-ray evidence of disease. Tonsillectomy and the removal of the dental infection were strongly urged but he procrastinated.

In August, 1926, he had an acute attack of tonsillitis which confined him to bed with considerable joint pain present. Three diseased teeth were extracted in September and October, and in April, 1927, four more teeth which showed marked rarefaction were extracted. On the evening after this last extraction he had fever, a pulse of 120, and his left knee became stiff and painful. In May he had another mild sore throat and after repeated urging tonsillectomy was finally done in March, 1928. Before his focal infection was removed he had had recurrent joint pains and periods of fever at intervals of not over two or three months. Since

March, 1928, he has been entirely free of rheumatic manifestations of any kind. Fortunately during the entire period there has been no demonstrable change in size or in other heart findings.

Time will not permit a detailed discussion of other cardiovascular conditions. The incidence in this group was as follows:

Irritable heart	50.50 per 1000
Functional murmur	28.10
Hypertension—all forms	70.69
Peripheral arterio-sclerosis	17.56
General arterio-sclerosis	15.37
Chronic myocarditis	14.05
Aneurysm of aorta	1.31
Bundle branch-block	0.86

SYPHILIS

The incidence of syphilis was surprisingly low, being found in only fifty-five individuals (2.4 per cent) of the group of 2277. Thirty-one were under age 40, eight were over fifty. Although the incidence of syphilis for the entire group was 2.4 per cent the incidence among the laborers was only 2.2 per cent, while it was 3.4 per cent for the group of skilled workers which included foremen, welders, and inspectors. The lowest incidence of 1.3 per cent was found in the group including engineers, technical experts, and executives. Twenty-eight gave no venereal history whatever, thirteen gave a history of syphilis, and fourteen gave a history of gonorrhoea. The blood Wassermann was strongly positive in twenty-one and negative or questionably negative in seventeen. Central nervous system syphilis was demonstrated in five of those with weakly positive or negative Wassermanns. Of the seventeen who had a negative or questionably negative blood Wassermann three had central nervous system syphilis. The others had strongly positive Kahns or developed positive Wassermanns after a provocative, salvarsan. Twenty-nine of this group of fifty-five are still employed and four are dead. Of the twenty-nine still employed five have had no recent Wassermann, in six it remains four plus or three plus, it is 2 plus in one, and the Wassermann is negative or questionably negative in seventeen.

During the five-year period thirty-nine of the 2277 men studied have died. The death rate per thousand is as follows:

Cardio-vascular disease	5.27
Tuberculosis	4.39
Malignant disease	3.07
Pneumonia	1.31

DEATHS

Syphilis, hernia, peritonitis, uremia, duodenal ulcer, and trauma have been responsible for one death each with a rate of 0.43 per thousand.

The average age at death of the twelve who died of cardiovascular disease was 58.8 years, of the seven who died from malignant disease 50.1 years, and of the ten who died from tuberculosis the average age was 35.9 years.

SUMMARY

This survey of what has been found in supposedly healthy workers serves to emphasize the fact that the supposed normal may not be so normal after all. To accomplish the greatest good, physical impairments should be discovered and corrected at the earliest possible time, an end most nearly achieved by painstaking, periodic health examinations. A health examination is not a thing to be passed over lightly. When frank disease is present its detection is comparatively easy but the time has passed when prevention might have been possible. We believe that work such as this may give to some of the group healthier and possibly longer lives. If it does, one step in progress toward the ultimate goal of adding to our present meagre knowledge of the causes of degenerative diseases will be made.

For discussion see page 183.

SECRETARIES' CONFERENCE

Saturday, March 28th is announced as the date of the Annual Conference of Secretaries of the component county medical societies and officers and councilors of the State Society. Following the custom of previous years, the conference will be held at the University Club, Milwaukee, as the rail point most easily available to the officers in the state.

Announcements of the program are to be mailed direct to the officers, but the meeting is open to any member of the State Society who may wish to attend.

Estimation of Permanent Disability Following Trauma*

By R. W. RICE, M. D.
Stevens Point

Physicians throughout the country, whether as general practitioners or specialists in a particular field of medicine, are frequently called upon to treat persons who meet with accidental injuries. Such injuries may occur while a person is working for his employer and subject to the provisions of the Workmen's Compensation Law or through hazards arising from the general use of the automobile.

Accidental injuries of these types are usually brought to the doctor's attention as an emergency case and require prompt medical and surgical care. Doctors who treat such cases should be able to estimate the permanent disabilities following such injuries, for they are ofttimes called upon to give their opinion relative to the amount of permanent disability sustained in order that the amount of damage may be fixed. Where the injury results in a permanent disability, as a rule no settlement can be made until the attending physician has given his opinion of the patient's physical condition and the amount of permanent impairment. Physicians must familiarize themselves with this phase of medical practice because of the increased extent of litigation which is arising as a result of automobile accidents and the increased hazards of industrial accidents, both of which necessitate the expert opinion of a medical man in order to determine the amount of physical impairment that has been sustained.

Physicians are often criticized because of their lack of knowledge of this subject. Lack of knowledge in this particular field of medical practice often results in considerable embarrassment to the physician, as well as a distinct harm to the injured individual seeking compensation for his personal injuries, when the doctor is called upon as a witness in the courts or before the Industrial Commissions of the various states, or when making a report to the employee or the employer. This lack of knowledge immediately becomes apparent in a physician when called upon to testify as an expert or as a witness in connection with automobile litigation or hearings before the Industrial Commission because the representative for the opposition will make the physician's lack of knowledge so glaringly apparent.

DISABILITIES

The particular disabilities which I am about to discuss are those sustained by employees in industry. Every physician has had cases of this kind at some time or other and might be required to make an estimate of the permanent disability.

Disabilities may be divided into four classes, namely: Temporary total, temporary partial, permanent partial and permanent total. Let us define the disabilities just mentioned in the order named.

(1) *Temporary total disability* means that an employee is totally disabled from work for a time as a result of the accidental injury. When the individual is discharged by the attending physician, he has made complete recovery and his physical condition is the same as it was before the accident.

(2) *Temporary partial disability* means that the employee is able to do only a part of his usual work or earn only a part of his regular wage over a period of time following the injury, and this period continues until such time as the individual has made complete recovery and his condition is again the same as it was prior to the accident.

(3) *Permanent partial disability* means that the employee has suffered permanent impairment of a member of the body—or, we might say, it is the permanent loss of function or loss of use of part of his normal physical faculty.

(4) *Permanent total disability* means that the employee is so physically impaired that he will never be able to pursue any gainful occupation.

* Presented before 89th Anniversary Meeting, State Medical Society of Wisconsin, Milwaukee, September, 1930.

I will here illustrate the course followed in a compensation case from the inception of the injury to the time the individual is finally discharged by the attending physician and is again able to resume his employment.

Let us take a compound, comminuted fracture of the tibia and fibula involving the ankle joint. After the necessary surgical treatment has been rendered immediately following the injury, the attending physician should make a detailed report covering the history obtained from the patient, the physical findings, and treatment. This report should contain an estimate of the probable period of temporary disability or the length of time which will have to elapse before the patient is again able to return to some form of work. When the doctor discharges the individual as fully recovered and again able to return to some form of employment he should make a report of this fact together with an opinion as to whether or not there will be any permanent disability resulting. The permanent disability should not be estimated for at least three or four months after the patient again returns to work, during which time he has had an opportunity to use the injured leg so that there will be little or no atrophy due to non-use at the time the estimation of permanent disability is taken under consideration. Individual cases may vary; in some instances full recovery is brought about within a period of three to four months, while in others full recovery is not established for a period of possibly six to eight months. The time within which healing should be complete or the best possible recovery made varies with the type of fracture, and the physical and mental condition of the patient. In some instances there is no callus formation, consequently the healing period is very much prolonged. Physicians must always be on guard in the treatment of this type of case, as well as in other types of fracture.

Doctors must encourage patients to aid them in securing rapid recovery. It has been my experience that some patients are inclined to favor the injured member, and in some cases to the extent of actual malingering. Then again one may have cases where individuals are of such mental type that encouragement is necessary to bring about a satisfactory recovery.

In the estimation of permanent disability resulting from a fracture of the tibia and fibula involving the ankle joint as previously outlined, many factors must be taken into consideration. Among them are observation of the patient when he arrives at the office, the nature of his gait and general physical appearance. The complaints of the patient are also important. When observing the patient it is well to note whether he walks with a limp; whether or not such limp is marked or slight.

After the individual has presented himself for examination the physician should obtain the injured one's version of the accident and record it as he describes it. Sometimes it is necessary to frequently interrupt him by questions in order that you, as a physician, get a clear and comprehensive picture of how this accident occurred. After the history is obtained, a complete physical examination of the injured leg should be made. The injured extremity must be exposed sufficiently to enable the doctor to ascertain the function of the leg beyond the point of injury. After the leg is exposed, a close inspection should be made to determine whether or not the scar is well healed; whether or not the scar tissue adheres to the subcutaneous tissue; whether or not there is any bowing at the site of fracture; whether or not there is any atrophy; whether or not there is any swelling. All these factors should be taken into consideration and a comparison made with the uninjured leg, assuming, of course, that the uninjured leg is normal in all respects. The injured leg should be very carefully palpated to determine whether there are any areas of hypersensitiveness; whether or not motion is limited or restricted in any way and whether or not the circulation is interfered with.

Measurements of the foot and leg must be made *very carefully* and a comparison made with the uninjured foot and leg to determine whether or not there is any shortening of the injured extremity. Great care must be taken so that no discrepancy arises in the measurements. The patient should be

in a relaxed, reclining position and both legs fully extended. Steel tape marked in centimeters should be used. Steel tape is used because extreme accuracy is required. Where ordinary tape is used inaccuracy results because the divisions are not sufficiently minute and cloth tape has a tendency to give when stretched or pulled.

X-ray examination should always be made to determine the position of the bones at the point of fracture and the general appearance of the bone. It is important that both anteroposterior and lateral views be taken.

To determine the permanent disability in this type of case it is necessary to make a comparison between the physical impairment and loss of function of the injured foot and a normal foot and ankle. The examining physician must give an estimation of the permanent disability of the injured foot in terms of percentage, using as a basis a normal foot as 100 per cent. Another method the examiner may use is to compare the injured and disabled foot with a foot amputated at the ankle joint, such amputation being considered as 100 per cent loss.

Let us assume that the final result obtained in a similar case might be a complete ankylosis at the ankle. Physicians are sometimes inclined to estimate or rate such a foot as 100 per cent loss, losing sight of the fact that although motion is one of the important functions of the foot and that all motion may be lost in the ankle joint the foot is still of considerable value. For all practical purposes such a foot cannot be considered as more than 35 to 40 per cent disabled when compared with a normal foot.

In cases of complete ankylosis the percentage of permanent disability depends: (first) upon the decrease of functional efficiency due to loss of motion in the joint, and (second), the most important factor, upon the angle of fixation.

I have just outlined the method of estimating the disability in the lower extremity. The same procedure must be followed in the estimation of permanent disability in the upper extremities. The permanent disability in either the upper or lower extremities must always be estimated at the point where the disability exists.

Permanent disability is most difficult to estimate in injuries to the head and vertebral column. In considering injuries to the head I do not have in mind superficial wounds of the scalp which heal readily and which result in only short periods of temporary disability. The cases I have in mind are those of greater severity, such as skull fracture, concussion and cerebral contusion. Injuries of this kind are frequently followed by a greater or less degree of permanent disability. In cases of head injuries it is important for the doctor to obtain a history from the individual as to whether or not he was rendered unconscious, and if so, the period of such unconsciousness. It is also important to know whether there was bleeding from ears, nose or mouth.

A thorough physical examination is necessary if one is to determine the nature of the recovery. This should include an examination of the eye-grounds, and of all reflexes. A careful test of vision, hearing and reflexes will disclose whether or not there is any intra-cranial pathology remaining.

Headache is one of the symptoms most frequently encountered in these cases. It may be violent and continuous or it may be intermittent. The area of its location is frequently indefinite. Sometimes the exact spot may be located. The pain complained of may be that of a sensation of weight in the head, pounding, or pressure. It may be increased by work, changes of temperature, sudden movements of the head such as stooping or bending and other causes.

The greater percentage of the cases complain of dizziness. This comes on at irregular intervals. The patients frequently complain of this symptom when stooping or bending over. They do not stagger or fall although they often complain that they feel as though they are about to. This condition is not classed as a true vertigo because it is milder in character. These headaches and dizziness are often associated with complaints of insomnia, impaired memory and emotional instability. While all these symptoms may be present the general physical health may be, and usually is, excellent. In addition to the above symptoms paraplegia, hemiplegia, monoplegia or paralysis of a single nerve trunk may be found.

Stereoscopic radiograms of the skull should be taken in every case as they may reveal information not disclosed in the physical examination.

After the examination has been completed and it has been determined that disability is present an estimate of permanent disability must be made in terms of percentage. The condition of the individual at the time of examination must be compared with his condition prior to the injury, at which time he was capable of performing work such as any normal individual could perform. The mere fact that he is unable to do the work at which he was engaged prior to the injury does not constitute 100 per cent permanent total disability, as such individual might work at some other occupation at which he is able to render the services of a normal person.

In determining permanent disability in cases of back injury the same procedure is followed that I have just outlined in connection with cases involving head injury.

CONCLUSION

A physician who is called upon to make an estimate of permanent disability must be constantly on guard to determine whether or not the individual is malingering. If it is found that there is any malingering, such fact must be taken into consideration in the estimation of permanent disability. Patients are prone to exaggerate their condition for the purpose of increasing the amount of compensation to which they may be entitled.

While I believe that I have not presented the subject as fully as its importance deserves, I feel certain that you may have formulated some helpful conclusions from my discussion.

For discussion see page 183.

The Diagnosis and Treatment of Infections of the Hand*

By ALBERT TORMEY, M. D.
Madison

In 1929 there were 22,630 industrial compensation cases in the state of Wisconsin. Of this number, 7,441 or 32.9 per cent were hand injuries of which 1,293 or 17.4 per cent were infected. The total cost for indemnity and medical aid amounted to $423,243.00.

The fact that approximately one-third of all the compensation cases in this state are due to injuries to the hand, to say nothing of the thousands of non-compensable cases, is sufficient to present this subject for discussion today.

The first monograph on the subject was written in 1859 by Bauchet, but it was not until 1911 that this subject was clearly and scientifically presented by Kanavel, who deserves all the credit given him for this masterpiece.

Infections of the hand may be divided into five groups, namely:

1. Infections of the subcutaneous tissue spaces.
2. The lymphatic infections, superficial and deep.
3. Infections of the tendon sheaths.
4. Infections of the fascial spaces of the hand.
5. Infections of the bones and joints of the hand and wrist.

The most severe of the five groups are the lymphatic infections, infections of the tendon sheaths, and the infections of the fascial spaces.

(1) SUBCUTANEOUS SPACES

The distal phalanx is the most frequently involved of the subcutaneous tissues and for the proper treatment of this type of infection the anatomical structure of the phalanx must be remembered. The pulp of this part of the finger may be considered as a closed space. The epithelium is thick and the fat bundles are separated by multiple strands of connective tissue which run at right angles to the bone. Infection in this space gives intense throbbing pain and, unless it is drained quickly and properly, osteomyelitis of the phalanx is bound to oc-

* Presented before the 89th Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, Sept. 1930.

cur, due to the cutting off of the blood supply by pressure and invasion of the organism. Koch advises against the use of the old horse-shoe incision as it leaves an ugly scar and sometimes an area of anesthesia at the tip of the finger. A lateral incision will suffice providing that after the skin has been incised, the scalpel is pushed across the closed space and the bundles of connective tissue are incised at right angles. This will provide the necessary drainage. Hot boric acid dressings for three to four days will suffice to heal the infection.

Another very common infection which is painful and at times very long-drawn out is the "run-around" or paronychia. The pus generally gets under the nail bed and the best results are obtained by making an incision on both sides of the nail, freeing the root, and amputating it with a sharp scissors. One must be careful in making the incision not to cut the nail bed, for if this is done a split finger-nail will result.

The third type of superficial infection is found on the dorsal surface of the proximal phalanx which is due to a hair follicle infection and a carbuncle at this location is not unusual. It will cause considerable swelling of the finger as well as the dorsum of the hand, but with proper incision and hot packs the infection will clear up rapidly.

The fourth type of superficial infection is found on the palm at the metacarpal-phalangeal joint, generally in laboring men with thick calloused hands and is known as a frog felon or collar-button abscess on account of its shape when it penetrates into the deep tissues. (Fig. 1). Early incision and deep drainage is necessary to cure this condition.

Fig. 1. Frog felon or collar button abscess.

(2) LYMPHATIC INFECTIONS

Acute lymphatic infections often arise from some minor injury such as a slight abrasion or pin prick on the fingers or thumb and may give rise to alarming symptoms such as chills, fever, and general malaise. It must be remembered that the hand is covered by lymphatics which drain toward the dorsum. This accounts for the great swelling of the back of the hand in cases of palmar infections. Infections of the little and ring fingers drain to the glands of the elbow and thence to the axilla, while those of the thumb, index and middle fingers lead directly to the axilla. Because of this, infections of the thumb, index and middle fingers may lead to a general septicemia. According to Kanavel fifteen per cent of the cases of infection of the middle finger drain directly into the supra-clavicular glands and may produce serious systemic symptoms very early. These infections are usually streptococcic and should be hospitalized if possible, where they are treated with masterly inactivity, rest in bed, voluminous hot boric acid dressings, involving the entire hand and arm, large quantities of fluids, good elimination and incision only in the presence of localized pus.

(3) TENDON SHEATH INFECTIONS

The most serious infection of the hand is that of the tendon sheaths. It must be recognized early as it spreads with remarkable rapidity and destroys the tendon sheath and the tendon itself, if not properly drained. The tendon sheaths on the palmar surface of the hand are frequently infected and the size of the primary wound is of no importance. The sheath may become infected from a pin prick, sliver, or an extensive wound.

It is important to remember that the sheaths of the flexors of the index, middle, and ring fingers, extend from the proximal end of the distal phalanx, a thumb's breadth into the palm. The sheath of the flexor tendon of the little finger extends from the distal phalanx into the palm of the hand. It continues as the ulnar bursa, a thumb's

breadth above the anterior annular ligament. The sheath of the long flexor tendon of the thumb extends from the distal phalanx into the palm. It continues as the radial bursa, a thumb's breadth or less above the anterior annular ligament. These bursae, in most cases, communicate with one another near the wrist.

The cardinal symptoms and signs of tendon sheath infections are:

(1) Pain and tenderness over the course of the sheath.

(2) The infected finger is held in a slightly flexed position and fairly rigid.

(3) Exquisite pain in extending the finger which is most marked at its proximal end.

(4) The entire finger is uniformly swollen as is the dorsum of the hand.

A diagnostic point for tendon sheath infection of the little finger is that there is a point of maximum tenderness just proximal to the point where the distal flexion crease crosses the flexor tendon of the fifth finger. At this point the tendon sheath lies close to the surface and is not covered by overlying muscles.

As soon as the diagnosis has been made drainage must be instituted. It is fatal to be too conservative. The old methods of hot packs and poultices must be discarded. The important point in the treatment of these conditions is to establish drainage of the sheath and thus prevent the spread of the infection into the palm of the hand. The patient should be given a general anesthetic, either ether, ethylene, or nitrous oxide, and the operation performed in a bloodless field, which can easily be obtained with the aid of a blood pressure apparatus. The infected finger should be incised on the lateral aspect to avoid destruction of the nerves, blood vessels and flexion creases. This incision should be extended over any lumbrical spaces involved making a large enough incision so that the sheath can be seen and examined. Owing to the great thickness of the finger, on account of the edema present, the tendon sheath is frequently not opened. It is much better to have the opening too large than too small, because in small incisions the opening soon becomes closed by prolapsing tissue. To stop oozing after operation and to keep the wound edges widely separated, it is well to place a small pack of gauze saturated with petrolatum between the edges for twenty-four to thirty-six hours. The hand is then covered with a large hot boric acid solution dressing which is moistened every two hours and changed in twenty-four hours. If there is a tendency at any time for the tendon to prolapse the finger should be held in extension. In three to four days the acute symptoms have usually subsided and a warm arm bath may be used for fifteen to twenty minutes, twice a day. After the hand has been soaked in a sterile solution it is placed on a sterile towel and dried with an electric lamp or zoalite and then covered with a dry dressing. The patient is urged to move his fingers frequently while his hand is in the warm water bath to prevent the formation of adhesions. During his convalescence a cock-up splint is also applied to hold the hand in the position of function. As soon as the danger of lighting up the infection is passed, physiotherapy and active exercises are begun.

Infections of the tendon sheath of the little finger and thumb give the same symptoms as described above. However, owing to their relationship with the ulnar and radial bursae the incision is much longer and should be properly placed. Kanavel states that in some cases infection of the sheath of the little finger is limited to the finger itself, as there is a congenital separation of the tendon sheath from the ulnar bursa near the metacarpal phalangeal joint. This will confine the infection to the tendon sheath for some time and the bursa should not be opened unless we know that pus is present. If pus is present an incision is made extending from the base of the little finger at the distal flexion crease toward the base of the palm. (Figure 2). When the anterior annular ligament is reached the pus can generally be seen coming from below the ligament and it will then be necessary to drain the bursa above the ligament. This is best done by making an incision on the ulnar side of the arm at a point about one and one-half inches above the tip of the ulna. This incision is made directly down

Fig. 2. Line of incision for infection of tendon sheath and ulnar bursa.

on the bone and an artery forceps is pushed across the flexor surface of this bone and the radius in the anterior interosseous space until the skin protrudes on the radial side. Another incision is made at this point and a through and through drain inserted. (Figure 3). The advantage of this incision is that it provides good drainage for the upper end of the bursa and does not injure important vessels and nerves. It should be at least three inches long and any pockets of pus between the tendons and muscles are widely opened by inserting a finger through the incision.

When the long flexor of the thumb is involved the incision should be carried down only to within a thumb's breadth of the lower border of the anterior annular ligament because the motor nerve to the thenar muscles passes across the sheath between this point and the lower edge of the anterior annular ligament. If this nerve, which is a branch of the median, is severed there will be loss of power of the thenar muscles, and this is as serious as loss of a tendon. Drainage of the upper end of the radial bursa is carried out as previously described.

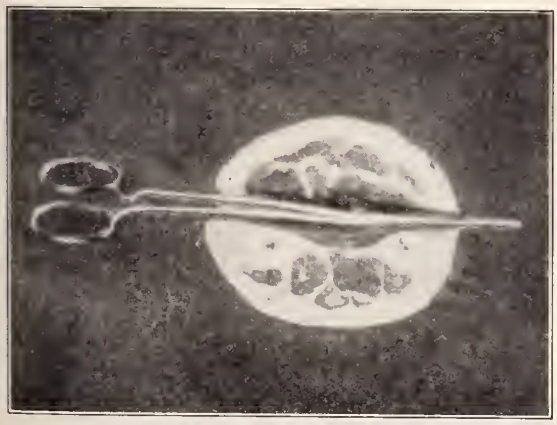

Fig. 3. Artery forceps in anterior interosseous space for drainage of upper end of radial and ulnar bursae.

If operated upon early, infections of the thumb and little finger may be arrested before rupture of the bursa takes place. If neglected for three or four days rupture takes place and the pus will extend into the forearm between the flexor tendons and the pronator quadratus. This will necessitate a second incision which is made in the middle of the forearm about one inch from the ulna on the flexor surface between the flexor sublimis and the flexor carpi ulnaris. The muscles should be retracted as it is not good technique to cut through any muscles as drainage will be inadequate. A rubber sleeve is inserted for twenty-four to forty-eight hours for drainage and a satisfactory result should be obtained.

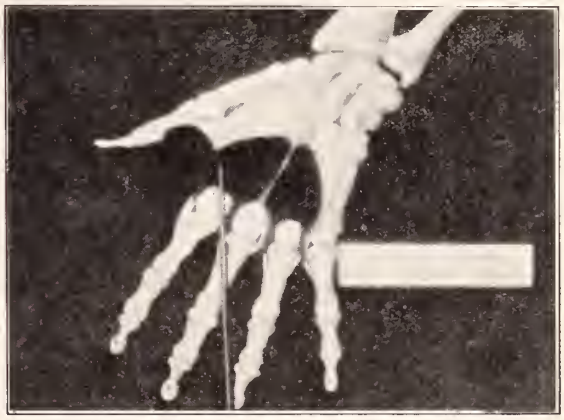

Fig. 4. Middle palmar and thenar space.

Tendon sheaths on the dorsum are seldom infected. The symptoms are localized swelling over their anatomic distribution, with tenderness and fever. Free incision will control the infection.

(4) FASCIAL SPACES OF THE HAND

The two most important fascial spaces in the hand are the middle palmar space and the thenar space. The middle palmar space lies to the ulnar side of the middle metacarpal bone and the thenar space lies to the radial side of the middle metacarpal bone.

Fig. 5. Cross section of hand showing middle palmar and thenar spaces.

Fig. 7. Cross section showing drain in thenar space.

They are hard to visualize but are well shown in Figures 4 and 5. They look like inverted truncated cones with the base toward the fingers. They lie on the metacarpal bones and the deep muscles of the hand, and under the flexor tendons and palmar fascia. They are infected by direct implantation, extension from frog felons, and from rupture of pus from infected tendon sheaths. The thenar space drains the index finger while the sheaths of the middle and fourth fingers generally rupture into the middle palmar surface.

Abscess of the middle palmar space will cause tenderness over the infected area, loss of concavity of the palm and pronounced swelling on the dorsum of the hand. Abscess of the thenar space causes tenderness and bulging of the thenar space on both the palmar and dorsal surfaces and moderate rigidity of the index finger. The incision for the thenar space should be made between the thumb and index finger on the radial side of the second metacarpal and on the level with its flexor surface, and an artery forceps pushed down as far as the middle metacarpal bone. (Figure 6). A rubber sleeve is inserted for three or four days and a satisfactory result is obtained. This incision will not injure any nerves, blood vessels or tendons, and is clearly shown on a cross section. (Figure 7). Opening of the middle palmar space is made between the middle and fourth fingers and a clamp is pushed down below the tendons to the middle metacarpal bone. (Figure 8). This is also drained with a rubber sleeve for twenty-four to forty-eight hours. The important point to remember is that these spaces lie below the tendons and deep drainage is necessary.

Fig. 6. Line of incision for infected thenar space.

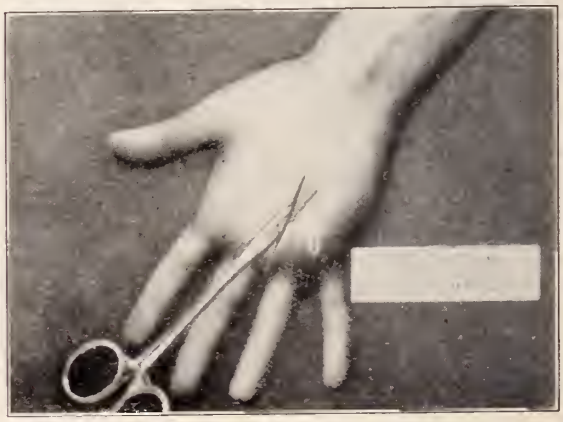

Fig. 8. Incision for drainage of middle palmar space.

(5) BONES AND JOINTS

Arthritis and osteomyelitis, often associated with finger and hand infections, may be primary conditions, especially in wounds which directly open into a joint, but they are common sequelae to long standing inflammation originating as a cellulitis or tenosynovitis.

There are three main types of bone infections of the hand.

(1) Those cases where the distal phalanx is the seat of osseous destruction.

(2) Where the finger proper is involved.

(3) Where the metacarpal and carpal bones are involved.

Osseous destruction of the distal phalanx is very common and frequently follows infection of the soft tissues as mentioned previously. The greater part of the terminal phalanx is a closed space, so that when inflammation occurs exudation results, the tension is raised and pressure on the veins leads to further exudation. Finally vascular thrombosis results, followed by necrosis of the diaphysis of the terminal phalanx, the base commonly escaping owing to the origin of its blood supply from without the closed space.

The proximal interphalangeal joint may become involved early, either primarily or secondarily, whereas, the metacarpal-phalangeal joint is seldom involved. The proximal phalanx escapes while the epiphysis and part of the diaphysis of the middle phalanx is destroyed. The bone becomes involved shortly after the joint is infected and necrosis follows. At times amputation of the finger is required, but every effort to save the bone should be made, especially if the thumb is involved, as it is the most important part of the hand.

A good point to remember regarding osteomyelitis of the metacarpals is that these bones are covered by the palmar fascia on one side and by a sheet of dense tissue on the dorsum which unites the tendons of the extensor communis digitorum. These dense sheets of tissue prevent the free egress of pus from the necrotic bones, and as a result, it is likely to burrow a considerable distance from the site of origin to its exit. In the early cases dorsal sinuses are most common and may appear at any point, but most frequently at the sides or near the knuckles.

Involvement of the wrist joint in chronic processes is characterized by multiple foci on both the dorsal and palmar surfaces.

In the treatment of bone and joint infections of the fingers Orr recommends the following technique:

"Under gas or ethylene anesthesia and with the finger well painted with tincture of iodine, incisions are made on each side of the finger the full length of the affected phalanx and through the periosteum. No curetting is done but with a probe or forceps it must be made certain that the subperiosteal area is thoroughly drained. No tubes or wicks are put in but a vaseline gauze dressing is placed lightly about the entire finger. Outside of this a wet alcohol dressing is put on. Then the entire hand is bandaged firmly but not tightly on a full length hand cock-up splint with the hand moderately dorsi-flexed and the fingers are slightly flexed. This splint is not to be removed nor are the dressings to be changed for a week. If there is any return of the throbbing pain or other signs of continued inflammation the affected finger may be kept moist through the dressing with 95 per cent alcohol. On no account, however, except for evident extension of the infection to other parts of the hand and arm are the dressings or the extremity to be disturbed.

"If secondary abscesses become manifest, incision and dressing followed by careful splinting should be done in the same manner. If this method is followed exactly, complete healing without complications of any kind will usually occur in about a week.

"In advanced cases where necrosis of bone has already occurred the technique is exactly the same except that at the primary operation, dead bone, if any, should be removed and the period to elapse until dressing is done should be longer—two weeks at least.

"Thorough drainage (not removal of all infected tissue) and efficient immobilization during the process of healing are essential to the complete success of this method.

"If, at the first dressing, healing is found to be incomplete, the wound should be

cleaned with iodine, a vaseline dressing should be put on and again allowed to remain undisturbed in the splint for at least one or two weeks. Healing without complications and with a minimum of disability may then be confidently anticipated.

"If the bones of the hand or wrist are involved they should be removed or the necrotic part curetted out."

Secondary Hemorrhage:

Erosion of the ulnar artery is the most common cause of secondary hemorrhage. When this complication occurs the vessel should be ligated as soon as possible.

An incision is made in the middle of the forearm on the ulnar side, the flexor carpi ulnaris is drawn to the ulnar side and the artery located and ligated proximally and distally.

After treatment:

In the after treatment three principles should be emphasized:

1. Aseptic care.
2. Maintenance of the position of function.
3. Early institution of active and passive motion.

Tendon sheath infections are generally streptococcic, and aseptic care is essential to prevent mixed infections with consequent necrosis of tendons and contractures.

The hand should be maintained in the position of function throughout the treatment and it is good technique to splint the hand during convalescence. A flexion splint may be necessary to secure the position of function and motility.

Active and passive massage should be instituted early in the course of the treatment.

Failure to observe these principles may end in contractures, loss of tendons and ankylosis. Observation of these principles with prompt application of adequate treatment should result in excellent function even after suppurative tenosynovitis.

The Industrial Commission of the state of Wisconsin with the aid of and advice of interested surgeons have worked out the following table of percentages of disability which follow infected or mutilated hands, and it should be used by all industrial surgeons when rendering a final report to the insurance company. If followed it should reduce controversies as to the per cent of disability in a given case to a minimum.

PERCENTAGE OF DISABILITIES TABLE

	Mid-Position	Complete extension and abduction
Fingers:		
Complete Ankylosis:		
Thumb:		
Distal joint only	25%	35%
Proximal joint only	15%	20%
Distal and proximal joints	45%	65%
Distal, proximal and carpo-metacarpal joints	85%	100%
Fingers:		
Distal joint only	25%	35%
Middle joint only	75%	85%
Proximal joint only	40%	50%
Distal and middle joints	85%	100%
Distal, middle and proximal joints	100%	100%

SUMMARY

1. The subject of hand infections is an economic as well as a surgical problem.
2. Employees must be educated to report any minor abrasions or lacerations and have it properly cared for, as the smallest wounds may be the most disastrous.
3. Lymphangitis cases should be hospitalized whenever possible.
4. Each hand infection should be carefully studied—a proper and early diagnosis made of the type and nature of the infection and the exact location of the pus determined.
5. The recognition and proper appreciation of tenderness on pressure is the basis of success in making a correct diagnosis.
6. Proper incisions should be made to allow adequate drainage.
7. Make the incision too long rather than too short.
8. All operative work should be done with the patient under a general anesthetic and in a bloodless field.
9. I draining the tendon sheaths of the fingers lateral incision should be used. The use of a through and through drainage above or under a tendon should be avoided as it will cause necrosis of the tendon.
10. Lymphatic infection, tendon sheath infection, and infection of fascial spaces present definite and unmistakable diagnostic criteria.
11. A severely infected hand requires as careful attention as a laparotomy or a fracture.

Discussion Papers of Squier, Tormey and Rice

Dr. Arthur W. Rogers (Oconomowoc): I would like to ask Dr. Squier if he can explain, or if he will discuss the relationship between rapidly increasing cases of heart disease and the tens of thousands of tonsils that are removed every year. Also if there is any connection between a simple chronic prostatitis and so-called sacro-iliac disease.

Dr. H. S. Smith (Cudahy): I have nothing of value to add to these papers, but I was especially interested in the first paper, presented by Dr. Squier. They were all very valuable and informative papers, but I was especially interested in Dr. Squier's paper, because we have just finished conducting a series of examinations for the employes at the plant with which I am connected, and we found some very interesting facts.

The point the doctor makes, or the subject of his paper, the discovery of disease in people who think themselves well, is one of the things which was especially interesting to us. We found quite a few instances of trouble where the patient was not conscious of any trouble. In the first place, we found quite a number of goiters which were just becoming toxic, or with beginning symptoms of hyperthyroidism. That thing alone, we considered, was well worth the time and energy expended in making these examinations.

Then we found numerous unsuspected heart lesions and were especially interested in the relationship between infected tonsils and teeth and various forms of rheumatism. We had quite a few instances of very remarkable clearing up of these symptoms very shortly after the removal of teeth, and in some instances, of tonsils. Although I think we found a larger number of teeth infections producing rheumatism than we did infected tonsils.

Dr. R. W. Rice (Stevens Point): I would like to ask Dr. Tormey what anesthetic is his choice in opening up serious palmar infections, such as he described.

Dr. C. C. Schneider (Milwaukee): This entire topic is of very great interest, I believe, to not only the industrial surgeon but the specialist who sees the end results of injuries, and the general practitioner who encounters many of these cases in civil practice.

The A. O. Smith Corporation and Dr. Squier are to be congratulated on the wonderful piece of work they are doing there, the thoroughness with which they are performing their work, and the splendid summary they are giving us of the effect of chronic infection on diseases which all of us encounter in our practice.

I would like to ask Dr. Squier whether they have made observations with regard to incipient osteoarthritis of the spine, as related to backaches and to the hazards of injury; whether osteoarthritis or Bright's disease are conducive to easy strain of the back, and, if so, whether the period of convalescence is aggravated by its presence.

In Dr. Tormey's discussion and in his pictures I noticed that he demonstrated incisions which pass the palmar creases of the fingers and even the palmar creases of the hand. Dr. Sterling Bunnell, of San Francisco, has treated the end results of the early surgery in these acute infections and has called attention to the disastrous effects of long incisions on the palmar surfaces of the fingers and hands. He interdicts the volar incision, which, of course, most of us are aware is wrong and also the anterolateral incision demonstrated in these slides, and recommends especially the *lateral* incision, confining these incisions to the spaces just to the side of the creases of the fingers rather than the sides of the phalanges, believing, as he has demonstrated, that the pulleys of the flexor tendons are anatomically situated at the side of the phalangeal bone, and that cutting these pulleys increases the disability in the palms and fingers. In the palm of the hand, he prefers to make his incision, in so far as it is possible, along the creases, the natural creases of the hand, maintaining that the scars of such incisions are less deforming and less incapacitating.

Some reference was made to the use of the hot water bath in the management of acute infection of the hand. I believe that the hot water bath, when used *after* adequate drainage has been accomplished, is deleterious to the progress of convalescence. The hot water, with the hand in the lowered position, causes a stewing of the immersed tissues, draws out the natural resistive forces in them, causes a concentration of blood in the part and a slowing up of both the blood and the lymphatic circulation, resulting in a general devitalizing and scarring of the tissues of the hand. Kanavel, in his original work, pointed out fifteen years ago that after adequate drainage was instituted the hot water bath should be discarded, and if moist heat is indicated it should be obtained by hot compresses with the part elevated.

Dr. Rice has opened up a most interesting subject which has been one of controversy among many of us. We all have appeared as representatives of injured individuals and have gotten into conflict with opposing medical opinion and have wondered how honest scientific men could be at such great variance. I believe the important factor to consider in the estimation of a disability, wherever it may be, must be a most careful examination of the part which is disabled, so that every factor which contributes to the function of that part may be comprehensively understood. The deformity must be considered also whether there is any shortening; and a point which is most mooted, the presence or absence of pain.

I believe that the difference that exists between the doctor appearing for the insurance company and the one appearing for the applicant is usually in evaluating the presence or absence of pain. To be

sure, the doctor himself cannot feel the pain and he has no accurate test by which he can determine its presence or absence and, therefore, must arrive at his conclusions on the basis of the reputation of the particular lesion at hand. To-wit, we know that fractures of the os calcis are usually painful, and, therefore, some consideration must be given to the presence of pain in these instances. On the contrary, fractures of the transverse processes of the vertebrae are not painful for a long period of time unless associated with other conditions in the spine, and, therefore, if pain is insisted upon, unless there is some other explanation for it, it may be discredited.

We should have a spirit of compromise when appearing before the Industrial Commission and, whenever possible, the medical men should get together and compromise their differences rather than make it necessary for the Industrial Commissioners, who are not medical experts, to arrive at some fair conclusion.

I believe the Industrial Commission has recently made a great stride in helping us to settle the disabilities of our injured workmen, in establishing arbitrarily the percentage of disability which exists in the presence of known dysfunctions, as ankylosis, and so forth. I believe this work should be extended and known anatomical defects should be classified, and their corresponding disabilities rated so that we will have something more tangible to work with.

Dr. F. C. Studley (Milwaukee): Dr. Rice has touched very closely on many of the disabilities of a physical character. I would like to know how to prognosticate or how to estimate the disability of the traumatic psychoneuroses, especially hysteria. I believe it was in 1917 that I collected thirty-nine cases which I examined and followed over eight years, and I found there were about fifty-five per cent of the traumatic hysterias and neurasthenias which made a recovery with partial defect. That is, after eight years of observation they were still complaining of various aches and pains and disabilities.

We know very well they never acquired their hysteria, because hysteria is never acquired. It is born with the person. I have observed, as I have appeared before the Industrial Commission in late years, that a good many of the young psychiatrists are stating that upon prompt money settlement every case of traumatic hysteria recovers. This has not been my experience. I would like to have Dr. Rice give us some information on the subject of prognosis in the psychoneuroses, and just how to estimate the disability in this class of cases.

Dr. Gilbert E. Seaman (Milwaukee): This has been a very interesting series of papers. I shall confine myself to commenting upon the last paper, the paper of Dr. Rice, with reference to the estimation of disabilities. It was a very excellent presentation, it seems to me.

The Industrial Commissions throughout the country, as Dr. Schneider suggested, have arrived at altogether too many arbitrary conclusions. There is no reason why they should arrive at an arbitrary conclusion, if they are willing to follow the experience of the various governments and the various organizations which have made a study of the science of the estimation of disability due to injury.

In the field of the special senses, going back many years, very important studies have been made by such men as Magnus and others in Germany and by Holt and Würdemann and others in this country, and by special committees of the American Medical Association. We have many scientific studies which, in my opinion, compensation boards, made up entirely, as they are, by laymen are not competent to take advantage of without scientific medical advice.

The best study and the best plan for the estimation of the loss of economic efficiency, due to injury, was made by the United States Veterans Bureau in the construction of their tables of disability. This was a study which made use of scientists and of physicians, and which covered a period of several years in its evolution, and they have arrived, not at guesses, but at definite conclusions, most of them backed up by scientific facts in the estimation of physical disabilities and economic loss from physical disabilities, due to accident and injury.

I do not approve of the medical profession accepting without question the arbitrary rulings of compensation commissions, made up of laymen in almost every instance, with relation to the economic loss and physical disabilities, due to injury. Our Wisconsin Commission, however, has shown a commendable regard for the scientific aspects of their work.

Mr. Voyta Wrabetz (Madison): This discussion is interesting. I may be in rather a strange field, because I am not a medical man. I am a member of the Industrial Commission. We are very glad that the Medical Society has set aside this half day, or at least a part of it, for a discussion of the thing in which we are very vitally interested.

In the first place, the doctor today stands in a very unique position so far as industrial injuries are concerned, because, rather wisely, the injured man has, you might say, only a sort of a secondary choice in the physician who is going to treat him. Therefore, it behooves the doctor attending an industrial cases to be careful in the treatment of the case and not merely as to how he treats the case but more particularly, because of the manner of his selection, to be particularly careful in developing the proper confidence of his patient in him.

Secondly, as Dr. Seaman says, we must depend upon the doctors in estimating disabilities. We do not pretend, nor have we at any time pretended, to know all there is to be known about the medical profession. We cannot know that when the medical profession itself does not know all that.

However, we have developed, in the field of estimating disabilities, two schedules which are, I

think, of considerable importance to injured men. The theory of the compensation law is to give injured men compensation as quickly and as surely and with as little argument about it as possible. Therefore, when you can develop schedules that are to determine cases as to well known disabilities, I believe you have made a great stride forward, because you eliminate the chance of argument and differences of medical opinion, as to such disabilities.

For instance, you may have a case come to you and have no schedule upon which you can base your disability. What I am to say is not an adverse criticism particularly, because doctors may have honest differences of opinion and they do have. One doctor will come in and on a certain disability give you an estimate of eighty per cent and another doctor may give five per cent or ten per cent. Then you know there is something wrong somewhere. It is to eliminate such situations that schedules are of great benefit.

We have two schedules. One is with respect to loss of vision, and let me tell you, and Dr. Seaman particularly, that that schedule was devised only after a long and careful study, taking into account the scientific studies that have been made by the eye men in their association, headed by a committee of which the chairman was some doctor in Chicago who has been chairman of that committee for quite a number of years. That was followed by a long study by doctors in Wisconsin to whom we submitted the proposition. Public hearings were held all over the state, and quite a number were held here in the city of Milwaukee.

Some time ago, we felt that it would be of advantage to have certain percentages of disability that would apply to some well known disabilities, for instance, ankylosis of the elbow in a certain position. If you have an ankylosis of the elbow in a certain position without pain or without any complicating conditions, merely ankylosis of the elbow, when you take into account the fact that the compensation law does not take into account particular occupations, then physicians should and must agree on the amount of disability that is sustained. If you have other complications that come into the picture, pain or some other condition, a hand in an extremely supinated position, or an extremely pronated position, then you have another condition which your schedule does not attempt to fix.

But when you have an arm in a favorable position, with a hand in a favorable position, with an elbow ankylosed in a favorable position, then doctors ought to be able to estimate with a fair degree of unanimity what the percentage is. And that is all we attempt to do.

After many years of experience, we have accumulated quite a bit of information based upon the estimates made by doctors in literally thousands of cases and we made some computation of estimates. This was rather tentative and published in the Wisconsin Medical Journal. We then conducted hearings all over the state, inviting all the doctors. They revised that plan and submitted the schedule at a final hearing in the city of Milwaukee.

We had a fair response from physicians, not as good as we had hoped, but nevertheless pretty good. I am sure if the surgeons in the state will write to us we will be glad to send them a copy of this estimate of disabilities and I am sure you will agree that the disabilities are fairly estimated.

After all, fairness in compensation cases means fairness to the injured man, because he is the one to bear the burden of disability through life and no amount of compensation is going to really compensate him for the damage that has been done to him.

Let me say further that in determining the percentage of disability on certain key positions, we took into account the literature on this subject written by doctors in this country and in Europe. We made a very careful study of this literature, although it was difficult to bring them to a certain common point, because some of them were estimating disabilities from the standpoint of function and others with loss of earning power. We had to evaluate all their various percentages and bring them down to a common basis. We also took into account not only the doctors to whom Dr. Seaman referred but also the report of the Veterans Bureau, and our estimates of disability follow very, very much the estimates made by the Veterans Bureau.

Dr. Squier (closing the discussion): Heart disease may be divided into two groups, chronic valvular heart disease and degenerative heart disease of advancing life. The span of life has increased in recent years, so that now the average duration of life is approximately fifty-five years. From five to seven years have been added. Consequently, more individuals are living to the time when they are subject to degenerative heart disease.

To give a homely example: If one had a pail with a dozen leaks and plugged all but one of them, the water would still run out. So if focal infection has any relation to degenerative diseases of later life, it will be of no avail to remove one focus and leave several others.

At the present time, we have so little knowledge of what focal infection does that one of the objects of my paper was to present the problem and to emphasize the fact that the future of medicine lies in a careful analysis and comparison of two groups—one group in which all foci of infection have been removed, and one in which focal infection remains. Such a study can only be consummated after a number of years of observation have elapsed.

Dr. Rogers asked about back pain in relation to chronic prostatitis. Chronic prostatitis is very important in the causation of back pain, and many individuals who have gone for a long time with chronic back pain without relief are relieved quite promptly after the chronic prostatitis has been treated.

Dr. O'Malley tells me that the period of disability is increased in those individuals who complain of back pain and have an old inactive osteoarthritis of the spine.

Dr. Tormey (closing the discussion): Replying to Dr. Rice in regard to anesthetics. All severe infections of the hand should have a general anesthetic, either ether, ethylene or nitrous oxide, and the operation performed in a bloodless field. This is easily obtained with the aid of a blood pressure apparatus.

In answer to Dr. Schneider, I wish to state that the lateral incision is always used in finger infections. Incision over the flexor surface of the finger will cause more scar contracture than if placed laterally. The main idea in draining is to make the incision large enough so that the prolapsing tissue will not dam up the drainage. It is much better to have too large an incision than too small.

It is not necessary to use drains in finger infections if incisions are properly placed, and an incision that is properly placed and large enough will drain out the pus without putting in rubber tubes or through and through drainage.

I use the hot water bath for severe tendon infections as well as for palmar infections but only for twenty minutes at a time, once or twice a day. This is followed by applications of dry heat as stated before which I find is very valuable.

"Spes Phthisica"*

By J. W. COON, M. D.
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It is doubtful if, in the world's history, such marvelous developments, such wonderful progress, has ever been made, as that which we of the present generation are witnessing. Along every avenue of human endeavor these developments have been carried, and such great things accomplished, that one cannot safely say today, that anything is impossible for tomorrow.

With all this development, medical science has kept well to the forefront. The last half century has witnessed progress undreamed of theretofore. Surgery now invades with relative impunity every part of the human body, accomplishing results that seem to be, and are in fact, little less than miraculous. Medical science has banished completely, or brought under control, diseases that have been the scourge of the human race for centuries. I need but mention a few of these, such as Asiatic cholera, typhus, bubonic plague, yellow fever, small pox, diphtheria, and typhoid fever.

We are here assembled as a part of a great organization which has for its objective the eradication of another great plague, one that almost dwarfs into insignificance those that are above mentioned, for they were but sporadic, terrible and terrifying it is true, during their periods of existence, but usually dying away, not to recur, perhaps for months or years. The disease in which we are specially interested, tuberculosis, the "Great White Plague" as it has been so aptly termed, has afflicted mankind from its earliest recorded history. It has always been present in all civilized races, and has caused, and is causing every year, more deaths, more suffering and more sorrow and poverty than all the great world plagues combined. Because it is so common, so everywhere prevalent, because we are all so familiar with it, it is taken as a matter of course as something unavoidable and therefore to be tolerated, and it has not been thought, until recent years, possible to conquer or to control it. But within our own time, because of a better knowledge of its nature, its methods of infection and transmission, the means of limiting or preventing its spread, combined with improved methods of treatment—because of all these facts, a new hope has arisen, a hope that tuberculosis, too, may ultimately be banished from the world, or if not banished completely in our time, that it may at least be brought under control even as small pox, typhoid fever, diphtheria and other great plagues of former years are now practically under control.

What has brought about this great change as regards tuberculosis? What great discovery, what outstanding achievement in medical science, the outstanding work of

* Read at the meeting of the Mississippi Valley Conference on Tuberculosis, at Grand Rapids, Michigan.

what great physician? Which of these has singly, or collectively, operated to bring about this great hope of ours? We can safely say, I think, that no single discovery, —although there have been many,—no single outstanding achievement,—although there have been scores of them, the work of no one physician,—although the history of medicine contains the names of thousands of great physicians who have contributed much to the world's medical history. No single one of these, has brought about the present knowledge of tuberculosis.

As in all lines of human progress, the great achievements of the present day are the result of the combined efforts of many minds, extending often over long periods of time, each adding a little, or much, to make up the sum total, so too, the present knowledge of tuberculosis has been developed during many years. One adding something to the general knowledge here, another there; theories proved or disproved, methods of treatment tried and abandoned, or retained if found of value. Here and there some brilliant discovery has been announced; some noted achievement proclaimed, some startling theory propounded, some definite cure assured, coming like meteors flashing across the sky to dazzle the eye for an instant, only to fade away, leaving the night darker than before. But steadily, if slowly, along with these disappointments, there has been added some proved and abiding knowledge of tuberculosis, sufficient to justify our hope for final victory, and to warrant our watchword "Spes Phthisica" or hope for the tuberculous.

THE INDIVIDUAL PATIENT

But in the individual patient this hope, this confident expectation, has always been the more or less outstanding attitude of mind. In the first place, when he has been told that he has tuberculosis, hoping, hoping against hope almost that there has been a mistaken diagnosis in his particular case. How many times have you, who are in the sanatorium work, had a patient come to you with every evidence of advanced tuberculosis, insisting over and over that he does not have tuberculosis; that he is simply tired out and run down, and only needs a short period of rest to completely restore him to normal health. Later, when he is finally convinced that he actually has tuberculosis, he invariably hopes, and usually confidently expects, that he will soon be well again.

In these days when so many do recover; when it is being so widely proclaimed that tuberculosis is curable; when on every hand are to be seen many who have recovered, it is not at all strange that the average patient should be hopeful of recovery in his own case. But this attitude of mind is not one that has come into existence during these recent years, with their improved methods of treatment, bringing about the greatly increased numbers of actual cures, but is one as old as the history of tuberculosis itself. In former days when a diagnosis of tuberculosis was almost equivalent to a sentence of death, the mental attitude of the patient was but little different from that of today. No matter what his condition, no matter how far the disease had advanced, he was usually hopeful that he was the exceptional case and that he would soon be well again.

Many of you, doubtless, have seen the terminal case of tuberculosis, wasted to a shadow, burning with fever, exhausted with coughing, with scarcely enough breath to speak aloud, telling of the great improvement that has already taken place, how much better he expects to be tomorrow, and planning what he will do when he is stronger and has gotten entirely well again.

All down the centuries this spirit has manifested itself, the patient actually believing, or at least confidently hoping for his ultimate recovery. So common, so universally prevalent, has been this attitude of mind that there has come into use the expression above quoted, "Spes Phthisica," signifying the hopeful attitude of mind of the consumptive. And it is not without some reason either, that this attitude of mind has had its existence. You who have had much to do with the treatment of tuberculosis have seen cases that, according to the best of our human judgment, were hopeless of recovery after a long period of no ap-

preciable improvement, begin finally to slowly improve and ultimately to recover. What has happened is that there has been built up within the system of the patient a resistance to, or immunity against, the action of the tubercle bacilli to such an extent that they have lost their power to do further harm.

We have learned that it is not wise to give a definite unfavorable prognosis in any case of tuberculosis, no matter how discouraging the outlook may be, or as one of my confreres used to say "You cannot say that any case of tuberculosis is hopeless until the patient has been dead and buried for at least forty-eight hours." An extravagant expression, of course, and yet one carrying a germ of truth that has given rise to the hope of the consumptive, the "Spes Phthisica."

TREATMENT

While consumption played a most important role as a death-dealing disease throughout all the years from Aristotle's and Galen's time, it was not until the early part of the nineteenth century that real knowledge as to its nature was worked out. Then we come across the names that now mean so much to us. Virchow and Villemin, with their contributions to the pathology of tuberculosis. Laennec and his fundamental discovery of the stethoscope, thus opening the avenue to the diagnosis of chest diseases. And the latter half of that same century brought us another great discovery, when, in the laboratory of a rural practitioner, Robert Koch, finally definite knowledge of the causative agent, the tubercle bacillus, was announced. Surely, with these great discoveries as to the cause, nature and diagnosis of tuberculosis as a basis to work on, it would seem that its cure, long hoped for, must be the next great discovery. But the treatment of tuberculosis, as we who have watched the varied methods come and go, is not yet definitely established. We have, as yet, no real specific for the cure of the disease. It is a poor year indeed that does not witness some widely heralded method of treatment come, and after a shorter or longer period of hopeful trial, quietly fade away to be only heard of through the files of the medical or secular press.

Following his announcement of the discovery of the tubercle bacillus, the development of tuberculin by Koch, seemed at first to have answered the ever questioning, ever hopeful consumptive. Time, however, showed this to be only another vain hope. There have been others: Friedmann with his turtle serum; later came Möllgaard and his well-designed, but, so far, impractical sanocrysin.

At the present time we are all watching hopefully the work of Calmette, who, by vaccinating new-born children of tuberculous parents, may have the means of wiping out the scourge. Certainly if the incidence of tuberculosis among children can be cut down, that means,—who can say how much of the battle has been won.

Rollier with his heliotherapy has finally given us a fairly satisfactory method of treating extra-pulmonary or surgical tuberculosis. Clinicians everywhere, however, recognize the ultraviolet ray as not always harmless when it comes to the question of pulmonary tuberculosis.

Forlanini, in reviving and making practical the earlier method of John B. Murphy of induced pneumothorax, has made it possible for large numbers of otherwise hopeless cases to regain not only health but economic independence. Sauerbruch, with his thoracoplasty and the more recent procedure of phrenicotomy or phrenic divulsion, has popularized, to a very great extent, the surgical treatment of tuberculosis.

And so the procession goes on, ever hopeful.

Through the years, though, emphasis has always been stressed on the hygienic, dietetic treatment, the absolute necessity for rest, fresh air, and nourishing food, the development of which has led to our present day sanatorium. The sanatorium today constitutes one of the most effective weapons of offense and defense in the crusade against tuberculosis, and perhaps a few words relative to its early history may be of interest.

THE SANATORIUM

Contrary to the general opinion, it would appear that in England rather than Germany, as it is usually thought, the sanatorium had its inception. A number of special hospitals for the treatment of some forms of tuberculosis were founded in England in the latter part of the eighteenth century, the oldest, so far as we know, being the Royal Sea-Bathing Infirmary for Scrofula, in Kent county which is still in existence. This was founded in 1791 for the poor only, and cared for cases of bone and joint tuberculosis, the pulmonary and laryngeal forms not being treated. The next oldest hospital for tuberculosis, and the first one to care exclusively for diseases of the lungs, was the Royal Hospital for Diseases of the Chest, founded in London in 1814. Brompton Hospital for Consumptives, the largest and most important of the English institutions was founded in 1841 in London.

The credit for the earliest attempt at what in these days would be termed sanatorium treatment, is probably due to George Brodington who in 1839 opened a small institution at Sutton Coldfield, Warwickshire, England. The following year, 1840, he published an "Essay on the Treatment of Pulmonary Tuberculosis," as carried out in his institution. He had not, as yet, designated it as a sanatorium. In his "Essay" he advocated cold dry air for the healing of ulcers and the closing of cavities of the lungs. He also advocated a generous diet consisting of fresh meats, eggs, farinaceous foods, beef tea, and milk, and insisted upon fresh air day and night. Strange as it may seem to us of today, Brodington, owing to the strenuous opposition of his colleagues, was obliged to abandon his method of treatment within a comparatively short time.

To Hermann Brehmer is usually given the credit for the first sanatorium which, after much opposition from the Prussian government, he succeeded in establishing at Goerbersdorf in 1859. Brehmer had as a pupil and co-worker the distinguished Peter Dettweiler, who, while heartily supporting his chief in most respects, held to the belief that by far the most valuable feature of sanatorium treatment consisted of rest, systematically followed over a long period. Dettweiler founded the celebrated institution at Falkenstein in 1874. From this time on sanatoria sprang up rapidly in Germany, which country soon took front rank in the institutional treatment of tuberculosis.

In the United States, as you all know, the pioneer sanatorium was founded at Saranac Lake in the Adirondacks by our beloved and revered Trudeau, to whom, more probably than to any other single individual, is due the inspiration that has made America the leader of all nations in the crusade against tuberculosis. With the exceedingly modest beginning of the "Little Red" cottage that was only large enough to house two patients, Trudeau Sanatorium has grown until it now has a capacity of 145. It is the center of a group of other institutions caring for as many more, and, with Saranac Lake, constitutes a Mecca for hundreds from all parts of the United States, as well as from many foreign countries, who seek the inspiration and help to be obtained from that wonderful tuberculosis center.

Beginning with the founding of the Adirondack Cottage Sanatorium in 1884, the sanatorium movement had spread so that by 1900 there were 33 sanatoria in the United States, with a combined capacity of 4217 beds. Still more marvelous has been the growth of sanatoria since that date, for the 1928 Sanatorium Directory, published by the National Tuberculosis Association, states that there were in that year 608 sanatoria, with a combined bed capacity of 72,723, and that there were at the time the directory was published, sanatoria under construction providing for over 2000 more beds, so that it is safe to say there must be today not far from 75,000 beds devoted to the care of those suffering from tuberculosis in the United States.

Primarily, the function of the sanatorium is to afford a place for the treatment, and the healing of the disease, if that be possible, in a person suffering from tuberculosis. To the individual patient, it goes without saying, that his own restoration to health seems the most important function of the sanatorium, and so it is in his particular instance, but considered in its broader aspects,

the benefits that may accrue to the public and to society in general, constitute a really more important function than the healing of the individual patient. But, in addition to caring for the physical welfare of the patient, the sanatorium must educate him to care for himself after leaving the institution, that he may maintain his restored health. It should instruct him as to the nature of the disease so that when he returns to his home he may, by precept and practice, teach others with whom he may come in contact, how to live so as to avoid, if possible, their becoming infected, or if already infected, to advise them as far as lies in his power, how to care for themselves that they, too, may regain their health and not be a menace to others. To be, in fact, a home missionary of health. In this manner will the sanatorium perform its most important function, that of an institution of health education.

The activities of all the correlated agencies, the national, state, municipal and local associations, with their many affiliated branches, an intensely interested medical profession, earnest social service agencies, research workers, sanatoria, preventoria, educational propaganda, etc., has resulted in the lowering of the tuberculosis death rate practically fifty per cent during the past three decades. This means the saving annually of tens of thousands of lives that otherwise would have been lost from tuberculosis in the United States alone. Not only these tens of thousands, but thousands of lives saved from other diseases because of the work of these health agencies, banded together primarily for the fight against tuberculosis.

With such a record of the past; with such powerful, thoroughly co-ordinated agencies now at work, surely we can look forward hopefully and confidently into the future.

CONCLUSION

So, in conclusion, I would say "Spes Phthisica," and again, and yet again "Spes Phthisica." Not only should we hope, but we should continue to work with faith that the "Substance of things hoped for," shall ultimately be achieved, and that the plague which has been a scourge to mankind during the ages past, shall be brought thoroughly under control, and to be finally a matter of history only.

SECTION ON RADIOLOGY

H. B. PODLASKY, M. D., Editor

The Orthopedist, the General Practitioner, and the X-Ray

By RALPH M. CARTER, M. D.
Green Bay

The field of knowledge encompassed by the medical sciences is today so vast that no individual can possibly be in possession of it all. It is in common recognition of this fact that the various specialties in the domain of medicine have arisen. But although these specialties are recognized as such, each is not divided from every other by fixed and unchanging boundaries. Progress is constantly being made; lines of division are forever changing, fields are enlarging and contracting, and overlapping occurs. To discuss briefly the interrelationship between the orthopedist, the general practitioner, and the roentgenologist is the object of this paper.

Until very recent years, orthopedics was looked upon merely as a rather unimportant division of general surgery; today the field of activity of the orthopedic surgeon has become so broadened that in order for him to do intelligent and successful work, in addition to his surgical knowledge and ability, he must also be familiar to a certain extent with the most recent advances in internal medicine, neurology, pediatrics, and roentgenology.

Formerly, orthopedics was concerned almost exclusively with the congenital de-

formities and crippling diseases of the young; today these conditions occupy but a very small portion of the field. Today, in addition, the orthopedic surgeon must have a thorough knowledge of bone diseases, of chronic joint inflammations such as tuberculosis, arthritis deformans, polyarthritis, etc., and the after-effects of injuries; he must know how to treat spastic and flaccid paralyses, and must be able to analyze the various muscle, ligament, and bony weaknesses which result from a faulty gait, an improper posture, or defective bodily development.

Two factors are chiefly responsible for this marked broadening of the field of orthopedic activity. The first of these is the experience gained from the World War, and the second is workmen's compensation legislation, from which has resulted an intensive study of industrial accidents, with more care and consequent improvement in their treatment.

Since most of the conditions mentioned above have to do with chronic disturbances of the motor apparatus, their treatment requires a fundamental knowledge of the anatomy and physiology of this apparatus; it also requires a special knowledge of the technique of orthopedic operations, of bandages, apparatus, gymnastics, massage, etc. Because every physician does not care for this kind of work, and finally, because the field is so extensive that it cannot be carried on successfully as a part of other activities, it is necessarily a specialty.

Nevertheless, orthopedics has not lost its meaning for the general practitioner. Every physician must possess a certain amount of orthopedic knowledge in the interest of general health and hygiene. Orthopedics prevents and overcomes crippling, and if the affection cannot be completely overcome, it makes the cripple capable of working and thus of self-support, either by means of operations or apparatus, or through investigation and suiting of employment to capability. Thus it is of great significance not only as regards bodily rehabilitation, but also in its social medical aspect.

In addition, a certain amount of definite knowledge of orthopedic principles and practice is almost a necessity for the general practitioner under modern conditions. This necessity has arisen as a result of workmen's compensation legislation. If, as has been previously said, such legislation has been an important factor in broadening the orthopedic field, it has had just as marked and important an influence upon general practice, and has given rise to a much closer relationship between these two fields than formerly existed. It is the general practitioner who takes care of most of the workmen injured in industry. While it is true that in the larger centers, specialists in the so-called "traumatic surgery" have arisen, nevertheless, in the smaller cities and towns such work, together with the very frequent automobile accidents, is taken care of by the man in general practice. A good functional end-result, obtained with as little loss of time as possible, is the important thing in such cases. With the introduction of accident legislation, and consequent greater attention to ultimate results by the medical profession, it soon became very evident that injured persons, even though healed in the older sense of the term, are usually far distant from useful functional healing. There is a great difference between anatomical healing and functional restoration. A fractured leg is anatomically healed when firm consolidation has taken place; but functional healing is only complete when the leg can be used without disability in daily life and work. To obtain the best possible anatomical and functional healing, a knowledge of orthopedic principles is necessary. Whether he realizes it or not, a certain amount of such knowledge has gradually been acquired by the general practitioner, as is shown by the steady improvement in end-results statistically evident.

What has been said sufficiently indicates the definite and fairly close relationship which exists between the orthopedic surgeon and the general practitioner. Many other convincing arguments could be advanced, but for the purpose of this paper, it is not necessary. It now remains to discuss the orthopedic value of the x-ray to the general practitioner.

X-RAY INTERPRETATIONS

Before proceeding to this, however, I should like to consider briefly the subject of x-ray films and their interpretation. In doing this, it must be distinctly understood that I am speaking from a general point of view, and not as an expert roentgenologist. I merely wish to call attention to certain points, which, in my opinion, should be matters of common knowledge to every practitioner of medicine having much to do with the x-ray, which includes most of us.

The x-ray belongs to the category of physical means of investigation. Roentgenography is naturally an important method of examination for the orthopedist. Very frequently he uses it to control the results which he has obtained by eye and hand; often it gives him information which he could get by no other means. But in addition to its capabilities, it has its corresponding limitations, and both of these must be known in order to properly utilize it and correctly evaluate the findings. A normal x-ray is no proof that bones and joints are sound. And very frequently the x-rays show changes which are not the underlying causes of the affliction for which the patient seeks our help. It is astonishing how frequently anomalies and variations are met with in individuals in which they were not even suspected.

Assuming that the technical requirements have been fulfilled, the limitations of roentgenography fall into 3 groups:

1. They are physical in nature when the difference in density between pathological and normal tissue is not sufficiently marked.
2. They are pathological-anatomical when the tissue changes are not roughly macroscopic, and
3. They are topographical anatomical when an isolated picture of the affected region is not possible.

In the presence of any of these conditions, a negative film will be obtained, even though disease be present.

A distinction must be made between x-ray findings and the diagnosis of the case, because they are two entirely different things. The x-ray findings consist in the careful observation and the objective description of the conditions shown on the film; the diagnosis is the meaning of these conditions from a pathological and clinical standpoint. The findings may be entirely correct, while the diagnosis is false. Since pathognomonic anatomical signs, such as filling defects in the stomach, or sequestrum formation in the bones, are relatively infrequent, radiograms are often apparently ambiguous upon first inspection. Consequently a careful and detailed study of the film is necessary before conclusions can be drawn. Such a study often gives a point of departure for further clinical investigation; it is a dangerous error to consider the clinical study finished when a brief examination has been made preliminary to taking an x-ray film, and to look upon the x-ray examination as the principal one. This is especially true if the film is negative; a beginning tuberculosis of the capsule of the knee-joint, for example, may give an entirely negative x-ray. An acute inflammation of the bone marrow is frequently absolutely negative for the first two or three weeks.

The following practical rules for studying x-ray films are given by Grashey:

1. As findings should be noted only what is clearly to be seen. Blurred negatives, poor pictures, and also indistinct structures in an otherwise good picture should not be read.
2. Findings should concern the involved region, which should be clearly shown.
3. In fractures, no conclusions should be drawn from a single plate.
4. If an x-ray picture shows a departure from the normal, the following questions present themselves:
   a. Are the changes artefacts?
   b. Do the changes arise from the body tissues, or from clothes, bandages, etc.?
   c. When the shadows arise from the body itself, are they pathologic or due to normal variations?
   d. How are the shadows which are found to be interpreted from an anatomico-pathological standpoint?
   e. Is the pathological picture surely and solely the cause of the condition complained of?

Turning now to a consideration of certain conditions which are of interest from a roentgenologic standpoint to orthopedist and general practitioner alike, one of the most important of these is fractures.

FRACTURES

It cannot be too strongly emphasized that every case of fracture or suspected fracture should be x-rayed in two planes at right angles to each other. To me, this proposition is so selfevident as to require no argument, and it forms a rule which is especially applicable in cases of suspected fracture. To neglect it is to invite a situation which may be extremely embarassing and difficult to explain, if indeed it does not later give rise to more serious complications for both physician and patient. In this, I speak with the conviction of experience. After practicing for twenty years, I thought that I had learned the lesson which I am now attempting to teach; within the past few months, contrary to my better judgment, I listened to a patient's plea of insufficient funds, and did not insist upon an x-ray which I felt should be taken. Some time later, another physician took this picture, and discovered a fracture. The position in which I was placed, together with its attendant possibilities, are sufficiently obvious and do not require extended comment. The only comfort which I could obtain for my wounded self-esteem was to reflect that upon several occasions in the past, I had discovered fractures which other doctors had overlooked.

I have mentioned this personal experience to emphasize the fact that x-rays should always be insisted upon in cases of suspected fracture. The only exception to this rule is under circumstances in which equipment for taking pictures is not available, but such circumstances are today very exceptional. It may be necessary to transport the patient a few miles, it is true, but such a proceeding is entirely justifiable.

If roentgenograms are important for diagnostic purposes, they are equally so for checking the results of treatment. Films should be taken both before and after reduction. While function is not entirely dependent upon structure, and while we often see cases with considerable bony deformity in which function is very good, nevertheless, in general it may be said that the nearer the structural replacement approaches the anatomical normal, the better the function will be. Consequently exact anatomical reposition should be sought for, although it is frequently impossible of attainment. The only way of checking it is by means of the x-ray.

Finally, the medico-legal importance of the use of the x-ray in the treatment of fractures must not be lost sight of. Under modern conditions of practice, the growing tendency of the courts is to hold the physician negligent who does not utilize it if it is in any way available. Consequently, the practitioner is entirely justified in insisting upon it, and is justified in refusing to take charge of the case if the patient will not permit films to be taken.

DISLOCATIONS

Closely related to fractures are dislocations, and what has just been said may be applied in general to them. As a rule, dislocations of the larger articulations of the extremities are readily diagnosed by their accompanying physical signs and symptoms; however, this does not hold true in certain dislocations in the wrist and ankle. Even though the diagnosis should appear to be entirely simple and clear, one film should be taken of every luxation, if not before, than after the reposition. Only in this way can one be certain that accompanying bony injuries, which are very frequent, are not overlooked. In symmetrical articulations, it is well to take views of both sides for comparison.

The subject of dislocations naturally leads to a consideration of other conditions affecting articulations. As has been said, intra-articular fractures are by no means infrequent, and should be carefully looked for following traumatism. In the acute inflammatory joint diseases, such as gonorrheal and streptococcic arthritis, the x-ray is often of the greatest value, not only from a differential diagnostic standpoint, but also for checking the results of treatment and for purposes of prognosis. Its value in bone and joint tuberculosis is so well-known that

no discussion is necessary. In chronic nontuberculous arthritis, under which term Timbrell Fisher groups the conditions which have been variously described as proliferative and atrophic arthritis, arthritis deformans, rheumatoid arthritis, etc., roentgenography is again of great value in differential diagnosis and prognosis. The same is true of the arthropathies, such as Charcot's disease of the joints.

Even a brief discussion of all the various conditions which concern both orthopedist and general practitioner, and in which roentgenography is indicated is not possible within the limits of a paper such as this. A few of the commoner ones have just been mentioned; others readily suggest themselves. Such are diseases and injuries of the spinal column, tuberculosis, syphilis, spondylitis deformans and osteoarthritis, compression fractures of the vertebral bodies and fracture dislocations; cases of persistent brachial neuritis, leading to a suspicion of cervical rib; affections of bone, tuberculosis, syphilis, chronic osteomyelitis, and tumors; general systemic affections, both congenital and acquired, with bony changes, rachitis, scurvy, osteomalacia, osteogenesis imperfecta, fetal chondrodystrophy, Mongolian idiocy; and finally, the various deformities. In all of these conditions, no examination is complete without the intelligent use of the x-ray. This list might be extended still further, but to do so is not necessary, as the extent of the field is sufficiently indicated for our purpose.

Acute osteomyelitis has been purposely omitted from the above enumeration. In this disease, in order to be effective, treatment must be vigorous and thorough, and it must be instituted as soon as possible after the onset. At this early stage, no changes in the bone marrow are visible by means of x-ray; nevertheless, the latter should be utilized for the purpose of ruling out other affections so far as possible. With a negative x-ray, the diagnosis must be made entirely upon the clinical findings, and surgical treatment immediately carried out. A life may be sacrificed by waiting for positive x-ray evidence of the disease; in any event, irreparable damage will have been done.

CONCLUSION

In conclusion, let me emphasize once more the close relationship which exists between the orthopedic surgeon and the general practitioner. Many of the diseases and conditions which have been mentioned above, if not the most of them, first come to the notice of the man in general practice. The successful outcome of a case usually rests upon early diagnosis and prompt institution of proper treatment. Accurate diagnosis is frequently impossible without the x-ray, therefore the latter constitutes one of the most important methods of investigation which we have. The field of roentgenography is today so specialized that the finer details of technique and interpretation must necessarily be left to the one best fitted for them by training and experience. Nevertheless, everyone engaged in the practice of medicine, whether as general practitioner, internist, general surgeon, orthopedic surgeon, or otherwise, should have a working knowledge of the capabilities and limitations of the x-ray, and should not hesitate to use it freely for purposes of diagnosis, even at the cost sometimes of considerable inconvenience to both the patient and himself. And a good general rule to follow, if in doubt as to whether or not an x-ray study is indicated, is to play safe and have it made.

New Diphtheria Regulations Adopted by State Board of Health

Additional regulations governing the treatment of diphtheria were among the important matters of business completed by the State Board of Health at its regular semi-annual meeting held in Madison on January 29, 1931.

Under the adopted amendments, diphtheria involving other parts of the body than the respiratory passages shall be controlled under the direction of the local health officer or the State Board of Health. In cases, where for any reason it is impossible to take release cultures, the period of quarantine shall be eight weeks from the date the disease was reported to the health officer.

THE JOURNAL CLINIC

A Diagnostic Problem

By L. M. WARFIELD, M. D.
Milwaukee

In a farm house near one of the small towns I saw a young man, 35 years of age, a farmer, who had been ailing since the first part of November, 1930. His family history was negative. In his past history he had always enjoyed exceptionally good health. He never remembers that he had any disease but measles as a child. He was married, and his wife had a healthy baby and there was no evidence of venereal disease. All his life he had been on a farm where he had done the usual farm work and had never had to lay off at any time. His appetite and digestion had always been good, bowels regular, and there were no nervous symptoms. His present illness began about the first part of November. He could not place just exactly when he did begin to feel not as well as usual. However, by Thanksgiving time he knew that he was not himself. He noticed that he became short of breath when he exerted himself, and that while he could walk around and be up all day, he was quite exhausted when evening came. He noticed also that gradually he began to have a little fever and that at night he frequently had sweats. Some five weeks before he was seen he developed jaundice and at that time he saw a doctor who treated him for the jaundice. He had no swelling of the feet, no headache, no great loss of weight. He did lose a few pounds.

About four weeks ago he developed a very distressing cough. That was not accompanied by any sputum except occasionally when it was slightly mucopurulent. The cough was worse at night and frequently kept him awake for some time. Although still coughing he was better when seen, the cough being dry with a sensation of tickling in the throat. All during his illness his appetite had been good and his bowels had been regular as usual.

On physical examination he was a well nourished muscular brunette. There did not seem to be any loss of weight although the muscles were slightly flabby. The skin was smooth, free from eruption, but definitely slightly jaundiced, the color being somewhat that described as "café au lait." The conjunctivae were also definitely yellow. The pupils were normal, reacted to light and the eyegrounds were normal, although the retinae were very pale. The teeth were in good condition, the gums firm but very pale. The tongue was somewhat smooth around the margin, but the papillae could be easily seen on the dorsum. There was no general glandular enlargement; no thyroid enlargement. The chest was well formed and the lungs were perfectly clear on percussion and auscultation. The heart apex was in the 5th interspace in the mid-clavicular line, dullness just at right border of the sternum. There was no definite thrill. At the apex there was a harsh systolic murmur which did not quite replace the first sound, was transmitted a short distance into the axilla and was heard over the body of the heart up to the third rib. Sounds at the base were clear with the second pulmonic slightly accented. The abdomen was flat, everywhere soft, the liver was not enlarged or palpable. The spleen was easily palpable, hard, not tender and extended three fingerbreadths below the costal margin. The knee jerks were present. There was no edema of the feet or ankles. There were no sensory disturbances. The genitalia were normal. His physician reported that the urine contained a small amount of albumin. It was dark in color and the stools had been somewhat colorless but recently color was returning. Blood pressure 120/80. The pulse soft, 104 to the minute. The temperature (12:00 noon) was 100°F.

For discussion see page 228.

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EDITORIALS

NURSING SERVICES

SOME of the important hospital nurses' training schools are suspending (or greatly reducing) their courses in view of the large number of unemployed nurses graduated in the past few years. This seems an intelligent thing to do because it has been urged by those in position to know that there has been an overproduction similar to that which is afflicting the whole business world.

In a previous editorial of some while back, we suggested that the economic troubles of the nurses are due rather more to a failure to provide proper distribution of their services than that there are too many nurses *per se*. Even in the present financial depression we see no reason to change that opinion. It is a matter of what the buyer, or potential buyer, considers good value. The business of the greatly overproduced movie palaces is lessened, no doubt, but few of the good theaters have closed. Similarly in the instance of women's ready-to-wear shops and many other purveyors. The production and purchases of automobiles have decreased greatly but it is still difficult to find convenient parking spaces along the curbs of our streets.

Meanwhile many families which ought to appreciate the value of good nursing service are not employing it. Frequently, as we pointed out before, it is not available when wanted because too many nurses, when money was easy, huddled together where competition now is stiffest.

This world of ours is not ready for the scrap heap, though there are many things in it that can be better adjusted. Real values like prolonged life and increased health are certain to be better appreciated as the result of changing views which business depressions always bring about. H. E. D.

SYMPTOM—COMPLEX

"Fugitives from the struggle of life into the haven of disease."

THERE is a pungent phrase (used by Puiner & Werner in an article published some time back) which is so descriptive of certain types of disordered patients that we raise the question if it does not deserve a permanent place in medical nomenclature?

The late war, plus the bounty of our Government in providing (in many instances too lavishly) for its disabled veterans made many victims of this "symptom-complex". Insurance, of one sort and another, and the generosity of juries in our law courts are responsible for the creation of many more.

"Fugitives from the struggle of life into the haven of disease." How much more truly descriptive than "railroad spine"; than neurasthenia of certain types; than "pauper", "bum", and many other terms that are really only *epithets* when *diagnoses* are called for first and scientific therapy next. H.E.D.

"THE MAINTENANCE MAN"

JIMMY is the best automobile mechanic I have ever employed upon my car so long as there is anything serious the matter with it. He can detect the slightest of false notes in the rhythm of the engine and goes unerringly to the seat of the trouble whether it be a fouled spark plug, adjustment of the timing gears, or a pitting in the distributor points. If the trouble goes deeper, down in the very bowels of the engine, Jimmy's joy is complete but is no wise influenced by any consideration of the size of the repair bill he may be able to run up on me. Indeed, charging for his services is as abhorrent to him as it is to many a professional gentleman who puts his work ahead of his hire.

Jimmy is very like a great many doctors I know in being a wonderful "trouble shooter" but a perfectly rotten maintenance man when it comes to the little rattles, squeaks, etc., in my car. When I try to employ him to get out these minor aggravations, he "pats me on the back," figuratively speaking, smiles tolerantly and unless I stand over him, he soon has his tools moved over to the running board of a more "serious case." No doctor could be sweeter to, or do less for a neurasthenic patient than Jimmy does for me when the, to his eyes, unessential squeaks and rattles get on my nerves.

Sometimes I wish Jimmy might get a nervous disorder or some other hygienic disturbance and then be incapable of finding any kind of a doctor interested in anything less radical and fascinating than trephining his skull. It would be a just retribution. But when it comes to that, perhaps there are here and there, doctors who ought to go up against Jimmy's intolerance of "nerves" due to squeaks and rattles. Maybe they would be better all round doctors as a consequence. H. E. D.

SUICIDE AND THE PRESS

IT HAS been said that if one hears or reads the same thing sufficiently often one begins to believe it. Too often one fails to analyze or philosophize concerning the facts of the case. This is the principle of all advertising. During the late war many of us were stirred almost to thoughts of murder because of the propaganda spread on the sheets of the daily press.

There is one large class of readers, the neurotic and emotionally unstable individuals, who clamor for the sensational and melodramatic. They can close their eyes and almost place themselves in the position of those about whom they read. In short, they are morbid and seek their kind, as the depressed individual hates the sunshine. These individuals are peculiarly susceptible to the lurid descriptions of suicides too frequently featured and illustrated by some of our papers.

Knowledge of these facts led me, a few years ago, to interview the editors of the Milwaukee daily papers, with the idea of presenting this matter to their attention so they might make the subject of suicide less conspicuous, and eliminate the gruesome details, particularly the methods used. My effort met with the uniform statement, "The public wants the news." As time passed, however, we had the satisfaction of observing a gradual soft-pedaling in this matter. Recently there was sent out from the office of the State Medical Society the following letter to every daily newspaper in the state:

> Suicides are always more numerous late in the year and early in the spring. They are more frequent in times of financial stress.
>
> Apropos of this, I wish to call your attention to the practice of the press in publishing and often illustrating the gruesome details of the ever increasing army of suicides. It might be said that the suicide's act is almost invariably the result of a mind that has always been poorly balanced or has become acutely so through sickness or stress. Such minds are ever open to suggestion and especially so to suggestion of an unfavorable character. These individuals are newspaper readers and the story of a suicide as graphically set forth by the press is only too often the influence which pushes them over the line by suggesting ways and means. Permit me to call your attention to the force of suggestion along this line in the suicide pact and also to the long list of suicides through the bichloride of mercury route following the minute description in the press of the suicide of a well known Atlantic banker a few years ago. I

might cite you many instances of this character, personal and otherwise, where such was the case.

The press will help all the public and injure none by not printing so many details of these tragedies. Why publish the means of suicide and thereby put into the minds of others ways and means to this end? Why so often illustrate these facts of wrecked lives?

The above comments are the result of 30 years' intimate contact with mental illness as physician in charge of an institution treating such cases, and not that of impulse or lack of consideration.

ARTHUR W. ROGERS, M.D.
Chairman of the Council.

Oconomowoc, Wis.

A similar letter sent out a few years ago brought forth six rather unsatisfactory replies. The recent letter brought over a score, from the leading papers in the state, all approving our suggestion. Two papers published special articles. We quote from one such article:

"It is conceded that a suicide act is the result of an unbalanced mind due to ill health, or stress in business. This paper established a policy some ten years ago of eliminating the details that the burden might be lightened upon the survivors. No good can be accomplished by bringing all of these details into the home, and then again, suggestion plays quite an important part upon those who may be in a mental attitude susceptible to following the same course. Not only have we refrained from headlining and broadcasting suicides, but in every instance where it was possible we have refrained from mentioning those who have undergone a temporary breakdown and are committed to state institutions. We want these unfortunates to come back and take their old places in community life, and if they are branded in the eyes of the public as insane, the task of regaining health and restoring confidence is retarded. In these times when there is financial stress, a newspaper functioning as a part of the community life owes a duty, and it seems we can best serve a municipality, county, or state by omitting reference so far as possible to suicides and commitments, where disordered minds are involved. We must remember that news of a suicide is not confined to the individual alone, but to the entire family, and that the burden, temporary though it may be, is a heavy one to bear on the part of those related."

Again, from another paper:

"It might be interesting for you to know that our paper, for nearly four years, has not used the word 'suicide' nor given the details in any account of local cases of self-destruction. We have also endeavored to eliminate the word 'suicide' from our telegraphic news reports in so far as possible."

A central Wisconsin editor remarks:

"We have noted that one suicide is usually followed by two or three more in rapid succession and there seems to be something to the theory that publicity induces others to take their lives."

We feel that an impression has been made, when we read from another letter:

"I appreciate the seriousness of the problem and I appreciate your writing us about it. Within the next few days I will try to formulate a policy for handling suicide stories that will be more satisfactory from a standpoint of public good."

Or:

"I feel that the duty of the Medical Society, as well as all other public-minded citizens, is to come out with a public appeal, setting forth the detriments of the policy of yellow press which disseminates that type of news, and appeal both to the publishers and to the readers that these practices should be eliminated."

I quote the following from a letter from the coroner of Milwaukee County:

"My lengthy experience convinces me and the records of this office confirm the fact that the power of suggestion is a factor in many suicides. Records also show that the manner of means used by suicides frequently follow in successive cases indicating the influence of suggestion."

We garner one great fact from the above. The press of Wisconsin desires to give the public news that is informative, constructive, and harmless. Our profession can help in directing editors along lines unfamiliar to them, and will be meeting a more than willing press. In each community the medical profession can wield much power along social lines, if we but give of our thought and time. A.W.R.

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LIST OF EXECUTIVE OFFICERS OF COUNTY MEDICAL SOCIETIES

County	President	Secretary
Ashland-Bayfield-Iron	W. J. Tucker, Ashland	J. W. Prentice, Ashland.
Barron-Washburn-Sawyer-Burnett	J. H Wallis, Rice Lake	E. R. Hering, Shell Lake.
Brown-Kewaunee	A. J. McCarey, Green Bay	E. S. Knox, Green Bay.
Calumet	A. C. Engel, New Holstein	A. F. Slaney, Hilbert.
Chippewa	F. T. McHugh, Chippewa Falls	J. A. Kelly, Chippewa Falls.
Clark	M. McGonigal, Loyal	E. L. Bradbury, Neillsville.
Columbia	A. J. Batty, Portage	H. E. Gillette, Pardeeville.
Crawford	A. J. McDowell, Soldiers Grove	C. A. Armstrong, Prairie du Chien.
Dane	F. J. Hodges, Madison	L. V. Littig, Madison.
Dodge	E. P. Webb, Beaver Dam	A. W. Hammond, Beaver Dam.
Door	John Hirschboeck, Forestville	T. C. Proctor, Sturgeon Bay.
Douglas	J. W. McGill, Superior	C. H. Christiansen, Superior.
Eau Claire and Associated Counties	E. E. Tupper, Eau Claire	P. G. Spelbring, Eau Claire.
Fond du Lac	H. A. Devine, Fond du Lac	H. R. Sharpe, Fond du Lac.
Grant	E. A. A. Dunn, Platteville	M. B. Glasier, Bloomington.
Green	W. B. Gnagi, Sr., Monroe	J. F. Mauermann, Monroe.
Green Lake-Waushara-Adams	J. M. Johnson, Ripon	A. J. Wiesender, Berlin.
Iowa	T. A. Hagerup, Dodgeville	H. M. Walker, Dodgeville.
Jefferson	Will Young, Ft. Atkinson	M. G. Peterson, Lake Mills.
Juneau	C. A. Vogel, Elroy	A. T. Gregory, Mauston.
Kenosha	W. H. Bennett, Kenosha	W. M. Lipman, Kenosha
La Crosse	W. J. Jones, La Crosse	R. L. Eagan, La Crosse.
Lafayette	R. B. Quinn, Darlington	W. B. Williams, Argyle.
Langlade	E. J. Donohue, Antigo	J. C. Wright, Antigo.
Lincoln	E. K. Morris, Merrill	W. H. Bayer, Merrill.
Manitowoc	W. G. Kemper, Manitowoc	C. H. Barnstein, Timothy.
Marathon	Joseph F. Smith, Wausau	Verne E. Eastman, Wausau.
Marinette-Florence	T. J. Redelings, Marinette	M. D. Bird, Marinette.
Milwaukee	E. L. Tharinger, Milwaukee	Theo. Wiprud, Ex. Sec'y, Milw.
Monroe	A. E. Winter, Tomah	H. H. Williams, Sparta.
Oconto	R. J. Goggins, Oconto Falls	G. W. Krahn, Oconto Falls.
Oneida-Forest-Vilas	C. D. Packard, Rhinelander	I. E. Schiek, Rhinelander.
Outagamie	C. D. Neidhold, Appleton	R. V. Landis, Appleton.
Pierce-St. Croix	J. H. Armstrong, New Richmond	A. E. McMahon, Glenwood City.
Polk	L. O. Simenstad, Osceola	Geo. B. Larson, Frederic
Portage	F. A. Marrs, Stevens Point	H. P. Benn, Stevens Point.
Price-Taylor	F. W. Mitchell, Medford	G. E. MacKinnon, Prentice.
Racine	J. F. Bennett, Burlington	Susan Jones, Racine.
Richland	Bertha Reynolds, Lone Rock	G. Benson, Richland Center.
Rock	G. K. Woolf, Janesville	R. C. Hartman, Janesville.
Sauk	A. L. Farnsworth, Baraboo	A. C. Edwards, Baraboo.
Shawano	C. E. Stubenvoll, Shawano	L. W. Peterson, Shawano.
Sheboygan	John Hansen, Glenbeulah	A. C. Radloff, Plymouth.
Trempealeau-Jackson-Buffalo	J. W. Lowe, Merrillan	R. L. MacCornack, Whitehall.
Vernon	W. M. Trowbridge, Viroqua	Wm. H. Remer, Chaseburg.
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Waukesha	W. B. Campbell, Waukesha	J. F. Wilkinson, Oconomowoc.
Waupaca	R. K. Irvine, Manawa	F. J. Pfeifer, New London
Winnebago	G. V. Lynch, Oshkosh	M. C. Haines, Oshkosh.
Wood	O. N. Mortensen, Wisconsin Rapids	W. G. Sexton, Marshfield.

SOCIETY PROCEEDINGS

BROWN-KEWAUNEE

The January meeting of the Brown-Kewaunee County Medical Society was held at the Hotel Beaumont, Green Bay, on the 20th. Dinner was served at six o'clock. About thirty-eight members were present. Immediately following the dinner, the meeting was called to order by Dr. A. J. McCarey, President. The minutes of the previous meeting were read and approved.

Dr. James C. Sargent, professor of urology, Marquette University, presented an explanation of the new method of "Prostatectomy with Primary Closure." This method was very beautifully visualized by moving pictures showing the various stages of the operation as carried out by himself and assistants. This was an unusually fine presentation of the subject and was very much appreciated by the Society.

Communications were read in regard to Dr. J. A. Hernandez's transfer from the Brown-Kewaunee County Medical Society to the Marathon County Medical Society. Communications read from the secretary of the society to Dr. A. J. Cramp of the Bureau of Investigation of the A. M. A., inviting him to speak before the Society on February 19th and Dr. Cramp's acceptance of the invitation.

A committee was appointed by the President to revise the by-laws of the Society. Members of the committee consist of: Dr. R. Carter, chairman; Dr. E. S. McNevins and Dr. C. J. Chloupek.

Ways and means of dealing with the question of preventive medicine and the indigent patient were discussed. The president appointed a committee to deal with this situation. Following are the members: Dr. T. J. Oliver, Dr. Fabian Gosin, Dr. G. Goggins, Dr. H. Atkinson. There being no other business the meeting was adjourned. E. S. K.

CALUMET

At a meeting of the Calumet County Medical Society held on November 13th, officers for 1931 were elected as follows: President, Dr. A. C. Engel, New Holstein; vice-president, Dr. N. J. Knauf, Chilton; secretary-treasurer, Dr. A. F. Slaney, Hilbert; censors, Drs. H. C. Krohn of New Holstein and J. J. Minahan of Chilton; delegates, Drs. J. W. Goggins of Chilton and F. P. Knauf of Kiel.

Several interesting talks were given by different members and problems both professionally and politically were discussed. Following the meeting, dinner was served at the Hotel Chilton. A. F. S.

DODGE

A meeting of the Dodge County Medical Society was held on January 20th at Lutheran Deaconess Hospital. The following officers were elected: President, Dr. E. P. Webb, Beaver Dam; vice-president, Dr. John Karsten, Horicon; secretary and treasurer, Dr. A. W. Hammond, Beaver Dam.

GREEN LAKE WAUSHARA-ADAMS

The Green Lake-Waushara-Adams County Medical Society and the Woman's Auxiliary of the Society held a joint meeting in Ripon on January 23rd in the assembly room of the Ripon Public Library. Preceding the meeting, dinner was served at the Pinette Tea Room. Members of the Auxiliary then were entertained at the home of Mrs. J. M. Johnson, where an evening of bridge was enjoyed.

Dr. J. E. Gonce, associate professor of pediatrics, University of Wisconsin, addressed the physicians on "Convalescent Serum" which was followed by a round table discussion and smoker.

LA CROSSE

The meeting of the La Crosse County Medical Society was called to order by the president at 8:30 P. M., February 17th, at the La Crosse Club.

The minutes of the previous meeting were read and approved as read.

The University Extension Department will put on a one-day Post-Graduate course in La Crosse Saturday, May 3rd, on the subject of diabetes. The moral support and co-operation of the Society members has been requested. The program will consist of noon luncheon, an afternoon session for the medical profession, and a public meeting in the evening.

The proposition was discussed by the members present. It was moved that the May meeting of the county society be dispensed with in favor of the post graduate meeting. The motion was carried.

Border Line Practice was brought up by Dr. E. H. Townsend. Several members have received letters from the Minnesota State Board of Examiners threatening legal action if they continue to attend patients in Minnesota without having Minnesota license. A motion was made, seconded, and carried, to refer the matter to the State Secretary for an opinion on the question.

Dr. Robert Burns of the Wisconsin General Hospital gave an interesting talk on "Osteomyelitis" which was illustrated with lantern slides. It was well discussed by the members present. R. L. E.

MARATHON

Dr. E. L. Sevringhaus, associate professor of medicine, University of Wisconsin, spoke on "Menopausal Disturbances and Hyperthyroidism" at a meeting of the Marathon County Medical Society on January 15th at St. Mary's Hospital, Wausau. A business session preceded the lecture.

Dr. Joseph W. Gale of Madison read a paper

on "Diseases of the Breast" before the monthly meeting of the Marathon County Medical Society on February 18th at the Wausau Memorial Hospital.

MILWAUKEE COUNTY

The monthly meeting of The Medical Society of Milwaukee County was held at the Hotel Pfister in the Wisteria Room on February 13th.

The meeting was called to order by Dr. E. L. Tharinger, president. Following the reading of the minutes and the executive secretary's report the scientific program was given.

Dr. E. J. Festerling presented a case report which was discussed by Dr. J. J. McGovern.

Dr. Carl W. Eberbach addressed the society on "Some Observations on the Injection Method in the Treatment of Varicose Veins."

Doctors Yaller, E. G. Festerling, D. V. Elconin, A. N. Baer, Edmund Mensing, Wm. MacKedon, and Robt. E. McDonald discussed the paper.

Dr. W. S. Middleton, associate professor of medicine, University of Wisconsin, addressed the society on "The Newer Concept of Pernicious Anemia and Its Relationship to Treatment."

Dr. Middleton's address was discussed by Doctors L. M. Warfield, L. F. Jermain, Norbert Enzer, and A. J. Patek.

This was one of the best meetings held by the society. Both subjects were splendidly presented and were very favorably commented upon.

The social hour followed the scientific session. Nearly all the members remained for this feature of the program.

There were 200 present at the meeting.

OUTAGAMIE

A combined clinic and meeting of the Outagamie County Medical Society was held at the Appleton Crippled Children's school on January 15th, in the afternoon and evening.

Dr. E. J. Berkheiser, a member of the staff of the Presbyterian Hospital in Chicago, conducted the clinic in the afternoon and in the evening, following a dinner, addressed the group on phases of orthopedic surgery. Members of the board of education, city and county nurses and the mayor of Appleton were guests at the meeting.

The Society held its February meeting at the Hotel Northern, Appleton, on the 19th. Dr. Charles F. Sawyer of Chicago delivered an address on "Bowel Obstruction."

POLK

Members of the Polk County Medical Society met on January 22nd at Balsam Lake as the guests of Dr. D. A. Maas of Webster. Dinner was served at the home of Mrs. Anna Davidson. After the dinner, members adjourned to the court house for their program. It was opened with the showing of a four-reel film entitled "Traumatic Surgery of the Extremities." Dr. R. G. Arveson of Frederic was speaker of the evening, his subject being "Traumatic Surgery of the Hand." Dr. A. N. Nelson of Clear Lake gave a brief explanation of the working of the Children's Code law and the duties of the welfare committee recently appointed.

PORTAGE

At the annual meeting of the Portage County Medical Society the following officers were elected: President, Dr. F. A. Marrs, Stevens Point; vice-president, Dr. W. W. Gregory, Stevens Point; secretary-treasurer, Dr. H. P. Benn, Stevens Point; delegate, Dr. E. P. Crosby, Stevens Point; alternate, Dr. E. E. Kidder, Stevens Point; censor, Dr. W. W. Gregory, Stevens Point.

ROCK

Dr. G. K. Wooll, Janesville, was elected president of the Rock County Medical Society at its annual meeting held in the Hotel Hilton, Beloit, January 27th. More than forty members were present.

Other officers who were named are Dr. H. E. Burger, Beloit, vice-president, and Dr. R. C. Hartman, Janesville, secretary-treasurer. For the past five years Dr. H. E. Kasten of Beloit has served as secretary, but because he is going abroad to study this year, Dr. Kasten declined to be a candidate for re-election.

Following the dinner a general discussion was had on various matters of business. One matter of importance taken up was the problem of charity work. At the present time there are various organizations in the county working to secure aid for charity patients. It was the opinion of the Society that one organization, under the supervision of the county society, should be in charge of charity work. The following men were appointed to investigate this problem: Dr. L. J. Friend, Beloit; Dr. J. R. Harvey, Footville, and Dr. A. S. Parker, Clinton.

The committee on hospital investigations also reported. The committee comprises Dr. G. W. Belting, Orfordville; Dr. W. A. Munn, Janesville, and Dr. G. K. Wooll, Janesville.

Twenty-four members of the Woman's Auxiliary to the Rock County Medical Society were present at the Auxiliary election of officers. Mrs. F. E. Brinckerhoff of Beloit was elected president; Mrs. T. O. Nuzum of Janesville, vice-president; Mrs. Harry Shearer, Edgerton, secretary, and Mrs. W. H. McGuire, Janesville, treasurer.

SHAWANO

The Shawano County Medical Society, at its meeting of January 21st, elected the following officers:

Dr. C. E. Stubenvoll, Shawano, president; Dr. L. W. Peterson, Shawano, secretary-treasurer; Dr. A. J. Gates, Tigerton, state delegate; Dr. E. E. Evenson, Wittenberg, alternate.

WINNEBAGO

The Winnebago County Medical Society held a meeting in conjunction with the Winnebago County Dental Society, Wednesday evening, January 21st, at the Athearn Hotel, Oshkosh.

Dr. G. V. I. Brown of Milwaukee gave an inter-

esting address on "Modern Plastic Surgical Development as Related to the General Practice of Medicine, Surgery and Dentistry."

Dr. Frederick F. Molt of Chicago conversed upon the subject "Oral Infections."

Both men illustrated their talks with stereopticon pictures.

The meeting was very well attended, about seventy members of the societies being present, with guests from the neighboring cities. M. C. H.

WOOD

The annual meeting of the Wood County Medical Society was held February 17th in Wisconsin Rapids. The following program was given:

1. Problems in Public Health—Dr. F. X. Pomainville, Wisconsin Rapids.
2. Intravenous Pyelography—Dr. Nathan Goldberg, Marshfield.
3. General Talk on Social Medicine—Dr. K. W. Doege, Marshfield.

At election of officers the following members were selected:

President, Dr. F. X. Pomainville, Wisconsin Rapids; vice-president, Dr. K. H. Doege, Marshfield; secretary-treasurer, Dr. W. G. Sexton, Marshfield.

Delegates to the State Medical Society meeting: Dr. F. X. Pomainville. Alternate, Dr. K. H. Doege. Censor for three years, Dr. R. P. Potter. W. G. S.

MILWAUKEE ACADEMY OF MEDICINE

Dr. Dallas B. Phemister, professor of surgery, University of Chicago, presented a paper on "The Pathological Changes in Fractures of the Neck of the Femur and Their Bearing on Treatment" at a meeting of the Milwaukee Academy of Medicine, on Tuesday evening, January 27th.

The following program was presented at a meeting of the Academy on Tuesday, February 10th:

1. Presentation of Patient with Cerebral Calcification and Tic Douloureux by Dr. E. J. Haberland.
2. Roentgenograms of Bones in Deficiency Diseases by Dr. Helen Zillmer.
3. The Present Status of Vitamines in Prevention and Treatment of Disease by Dr. M. G. Peterman.

MILWAUKEE OTO-OPHTHALMIC

The Milwaukee Oto-Ophthalmic Society on January 20th elected the following officers for the coming year: President, Dr. H. F. Wolters; vice-president, Dr. J. B. Marks; secretary-treasurer, Dr. O. P. Schoofs.

Dr. E. H. Tomb was speaker on the scientific program, presenting a paper on "Keratoconus," while Dr. T. F. McCormick discussed a case report on "Temporo-Sphenoidal Lobe Abscess."

The February meeting of this Society was held at the Wisconsin Club on the 17th. Dinner was served at six thirty.

Dr. Frank J. Novak, Jr., Chicago, read a paper on "The Newer Knowledge of Immunology and its Application in Oto-Laryngological Practice." Dr. R. O. Ebert, Oshkosh, presented "Some Interesting and Instructive Cases."

ROCK COUNTY AUXILIARY

One of the major projects of the Woman's Auxiliary of the Rock County Medical Society will be a more direct interest in Pinehurst Sanatorium, it was decided at a meeting of the committee held on February 5th in the home of Mrs. F. E. Brinkerhoff, Beloit, newly elected president.

The Auxiliary will endeavor to interest organizations in providing entertainment for Pinehurst and will ask garden clubs of Janesville, Beloit and similar associations in the county to assist in beautifying the grounds of the Sanatorium.

The following program committee was named: Mmes. Carl Neupert, Wayne A. Munn, T. O. Nuzum, all of Janesville; Pearl Hecker, Thomas Shinnick, and Clair Schram, of Beloit.

Members of the social and membership committee include Mmes. Frank Van Kirk, T. J. Snodgrass, Janesville; S. W. Forbush and Benjamin Fosse, Beloit.

Programs were planned for meetings up to the summer months. A luncheon was served preceding the meeting.

UNIVERSITY OF WISCONSIN

The University of Wisconsin Medical Society and the Biological Division of the University were sponsors of two lectures given by Professor Jules Duesberg of the University of Leige, Belgium, on Monday, February 9th, and Tuesday, February 10th. His subject was "Experimental Cytology." Professor Duesberg has been connected with the Institute of Embryology at Johns Hopkins University.

NEWS ITEMS AND PERSONALS

Dr. A. J. McDowell of Soldiers Grove is rapidly regaining his health and will be able to resume his practice soon, according to word received in February. Dr. McDowell was elected President of the State Society for the year 1931 but because of illness was unable to carry on the duties.

Dr. Gustave Windesheim, Kenosha, was re-elected president of the State Board of Health, at the meeting of the Board late in January. He was appointed a member of the State Board of Health in 1919 and has been president continuously since 1924.

Dr. H. E. Kasten, Beloit, gave the first of a series of health talks at the Beloit vocational school, as part of the student council cleanliness campaign. Dr. Kasten talked on "Cleanliness as Applied to Health."

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Dr. Fred J. Hodges, lecturer in radiology, University of Wisconsin, has accepted appointment as professor of roentgenology at the University of Michigan.

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At the annual meeting of the staff of St. Mary's Hospital, Wausau, Dr. Joseph F. Smith was renamed president and chief-of-staff. Dr. J. K. Trumbo was re-elected vice-president and Dr. W. C. Frenzel, secretary-treasurer.

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Dr. John Hansen of Glenbeulah received an injured knee cap when his car left the road after a collision with a team of horses near Armstrong Corners on highway 23.

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Dr. and Mrs. Frank Cary of Greenbush, Sheboygan county, are spending the winter months at Sarasota, Florida. They will return about May 1st.

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Doctors W. G. Sexton, Marshfield, W. J. Carson, Milwaukee, and C. G. Richards, Kenosha, attended the meeting of the Chicago Urological Society on January 22nd in Chicago.

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Dr. H. F. Beglinger, formerly of Oshkosh, has taken over the practice of the late Dr. D. J. Ryan of Neenah. Dr. Beglinger recently returned from a year's study in Vienna.

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Dr. and Mrs. Conrad Tasche and daughter, Miss Gladys, and Dr. Leslie Tasche, returned early in February from a three weeks' visit in Texas.

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At a meeting of the staff of St. Elizabeth Hospital, Appleton, the following officers were elected: Dr. J. B. MacLaren, chairman of the staff for the year; Dr. C. G. Maes, Kimberly, vice-chairman; Dr. W. J. Frawley, secretary and treasurer.

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Dr. C. A. Harper, state health officer, addressed a meeting of the Kiwanis Club of Monroe on February 5th.

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Dr. J. C. Colignon of Green Bay has been promoted from first lieutenant to captain in the medical reserves, according to word received from Washington, D. C.

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Diphtheria deaths have been reduced from the 1910 peak of 429 deaths to 72 in 1930, the lowest toll in diphtheria mortality in the history of the bureau of vital statistics of the state board of health.

The Journal and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

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Perhaps you want a certain kind of instrument which is not advertised in the Journal, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask the Journal about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want the Journal to serve you.

"Unflagging efforts to carry the immunization program into all corners of the state and to perpetuate it have been directly responsible," the bureau said.

—△—

Dr. Carl T. Clauson, formerly of Bloomer, on February 2nd became a member of the Galesville Clinic. He fills the place left vacant by the illness and removal of Dr. George Christiansen.

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Dr. S. M. B. Smith of Wausau is recovering from an operation which he underwent on January 22nd.

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Dr. W. D. Stovall, director of the state laboratory of hygiene, Madison, spoke before the February meeting of the Woman's Club of Sheboygan on "What We Know About Cancer and Methods Employed in its Control."

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Dr. J. J. Minahan of Chilton read a paper before a meeting of the county coroners held in December at Oshkosh.

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Dr. Richard W. Farnsworth, son of Dr. F. B. Farnsworth of the Munn-Farnsworth Clinic, Janesville, is now associated with this group. Dr. Farnsworth is a graduate of Harvard Medical School and served internships at Boston City Hospital and Peter Bent Brigham Hospital.

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Dr. W. W. Bauer, Racine, gave an address on maternity hygiene at the Girls' Vocational School.

Dr. Ralph M. Carter, Green Bay, attended a ten-day clinic on fractures and orthopedic work in Philadelphia early in February.

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Definite plans are being made toward the establishment of a community hospital at Wabeno. Local clubs and organizations are co-operating in raising a fund for its establishment. The hospital will have an eight-bed capacity. There will be an operating room, a delivery room, a combined supply and sterilizing room, an office for the nursing staff and a complete x-ray department.

The medical board of the hospital will be composed of Doctors P. J. Noer, O. S. Tenley and Rudolph J. Noer.

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Dr. Otho Fiedler, president-elect of the State Medical Society of Wisconsin, was elected president of the Northwest Regional Conference, at a meeting held in St. Paul on Sunday, February 8th. He succeeds Dr. C. B. Wright of Minneapolis. Mr. Vernon Blank, managing director of Iowa State Medical Association, was elected secretary succeeding Mr. J. G. Crownhart, secretary of the Wisconsin Society. The conference is composed of officers in the state societies of Wisconsin, Minnesota, Iowa, North and South Dakota, Nebraska, and Montana, and meets annually for round table discussion of problems that are common to the societies in the group.

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Dr. and Mrs. Eugene E. Neff, Madison, spent the last two weeks in February at Hot Springs.

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Dr. Charles R. Bardeen, dean of Medical School University of Wisconsin, attended the White House Conference on Child Health and Protection at Washington, D. C., Feb. 19-21.

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The home of Dr. W. T. Clark of Janesville was damaged by fire on Sunday, February 15th. The amount of the damage was estimated at $1400, the blaze being confined entirely to the roof and attic.

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Dr. Nathan Schneck, formerly of Chicago, has opened an office in the Commerce building, Manitowoc, for practice in eye, ear, nose, and throat diseases.

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Dr. W. G. MacLachlan, for the past 25 years a practicing physician at McFarland, has retired from active service. His practice has been taken over by Dr. E. B. Keck, a graduate of the University of Wisconsin Medical School. Dr. Keck recently returned from Germany where he took a postgraduate course.

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Dr. F. T. Clark, mayor of Waupun, has announced that he will not be a candidate for reelection at the spring election.

Dr. A. J. Cramp of the bureau of investigation, American Medical Association, gave a public address on "Patent Medicines" in the Green Bay Y. M. C. A. He also appeared the same day before the Green Bay Rotary Club.

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Dr. Otho Fiedler, Sheboygan, addressed the members of The Woman's Club of Sheboygan on February 11th, on the subject of "Tendencies of Modern Governments."

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Mr. Edward W. Arnold, well known territorial supervisor for Riggs Optical Company, has been selected as manager of the Company's Chicago office.

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Dr. and Mrs. J. P. Dean, Madison, spent a week in February at New Orleans and other points.

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A special papal blessing was conferred on February 18th upon Dr. Philip Fox, Madison, who is nearing 91 and who has been ill for several weeks. The honor was conferred by a representative of Archbishop S. A. Stritch, Milwaukee, who received a cablegram giving the honor to Dr. Fox from the Vatican.

MILWAUKEE

Dr. C. C. Schneider was elected president of the staff at the Deaconess Hospital on February 5th. Dr. J. B. Matthews was elected vice-president and Dr. E. J. Kettelhut, secretary and treasurer. Dr. Louis Fuerstenau was made chairman of the Surgical Department; Dr. J. H. Reynolds, chairman of the Medical Section, and Dr. John W. Truitt, chairman of the Eye, Ear, Nose and Throat Section.

—△—

Dr. M. W. Sherwood was elected Chief of Staff of the Milwaukee General Hospital at a meeting of the Hospital and Dispensary Association on February 6th. Dr. Gustav Hipke was named vice-chairman and Dr. E. F. Barth secretary and treasurer.

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Dr. J. F. Shimpa addressed the Mothercraft School of the Milwaukee Maternity Hospital and Dispensary Association on January 30th. His subject was "Care of the Baby."

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A son was born to Dr. and Mrs. R. W. Benton on January 23rd.

—△—

Mrs. G. H. Fellman, wife of Dr. G. H. Fellman, died on January 30th.

—△—

Dr. P. M. Currer, president-elect of The Medical Society of Milwaukee County, underwent a major operation at the Deaconess Hospital on January 31st. He is making satisfactory recovery.

Dr. and Mrs. Robert W. Blumenthal left on February 2nd for a motor trip to California by the southern route.

—△—

Appointment of a staff which will be in charge of the new Johnston Emergency Hospital was announced by Dr. J. P. Koehler, City Health Commissioner, on February 4th. The following are members of the active staff:

Surgical section: Doctors J. J. Adamkiewicz, L. J. Foley, W. F. Grotjan, H. H. Huber, W. L. MacKedon, J. B. Matthews, Edmund Mensing, A Montgomery, Karl Schlaepfer, R. M. Stark, Harvey E. Webb, A. J. Weber.

Pathologists: Doctors J. Grill, Edward L. Miloslavich.

Obstetricians: Doctors A. M. Bodden, S. DeNosaquo, H. J. Olson, J. H. Sure. Urologists: Doctors J. C. Sargent, W. J. McKillop. Orthopedic Surgeons: Doctors John O. Dieterle, J. W. Powers. Otolaryngologists: Doctors R. J. Muenzner, Ralph Sproule.

Roentgenologists: Doctors H. C. Dallwig, Addison Dorr. Medical Section: Doctors Paul A. Brehm, G. F. Fitzgerald, Stephen Cahana, J. J. McGovern, L. F. Ruschaupt, M. M. Spitz, T. L. Szlapka, F. A. Thompson. Ophthalmologists: Doctors C. S. Beebe, T. F. McCormick. Dermatological section: Dr. Leopold Schiller.

Pediatricians: Doctors A. L. Kastner, S. H. Lippitt, M. G. Peterman.

Alienists-neurologists: Doctors A. I. Wegge, W. F. Wegge. Toxicologists: Peter M. Sampson, Dr. J. C. Beck.

Consulting staff: Surgical—Doctors C. M. Nichols, C. A. Evans, H. A. Sifton, F. A. Stratton, Lewis C. Tisdale, chairman, R. G. Sayle, W. C. F. Witte, Aaron Yaffe. Pathologists: Doctor J. J. Seelman. Roentgenologists: Dr. C. A. Fortier, J. S. Jansen. Ophthalmologists: Dr. C. Messmer. Orthopedic surgeon: Dr. F. J. Gaenslen. Medical section: Doctors George R. Ernst, L. F. Jermain, Joseph Kahn, G. Kaumheimer, J. D. Madison, A. J. Patek, H. A. Reinhard. Pediatricians: Doctors J. Gurney Taylor, G. H. Fellman.

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Of the 10,652 cases treated by Milwaukee General Hospital during 1930, the charity cases numbered 7,168 according to the report given at the meeting of the Maternity Hospital and Dispensary Association on January 27. Mrs. Gustav A. Hipke was re-elected president of the Association.

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Dr. and Mrs. A. W. Gray left February 4th for Pasadena, Calif., where they will spend the remainder of the winter.

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A meeting of the Committee on the Practical Postgraduate Course in the Diagnosis of Chest Diseases was held on January 22nd. Details of the course will be announced shortly.

Dr. Joseph A. Russell left on February 3rd for California. He will be gone a month.

—△—

Dr. and Mrs. E. L. Baum motored to Naples, Fla., during February. They will be gone the remainder of the winter.

—△—

Dr. Elisabeth Seiler addressed the Washington School Parent-Teacher Association, Wauwatosa, on February 4th. Her topic was, "Why Success and Failure in School?"

—△—

Dr. E. A. Meyerding, St. Paul, Minn., secretary of the Minnesota State Medical Association, visited Milwaukee on January 21st. He was interested in the activities carried on by the Medical Society of Milwaukee County and came to make personal investigation.

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Dr. Robt. Dieterle of Milwaukee Sanitarium gave a talk on "Mental Health" before the Professional Men's Club on January 27th.

—△—

Dr. and Mrs. Gilbert Seaman left for Florida on February 6th.

—△—

Dr. O. H. Foerster returned from a visit to Ann Arbor on February 5th.

—△—

Dr. and Mrs. G. H. Dickinson announced the engagement of their daughter Kathryn to Mr. Louis B. Roen on January 31st.

—△—

Dr. and Mrs. H. A. Sifton left February 10th for California by way of the Panama Canal.

—△—

A daughter was born to Dr. and Mrs. Millard Tufts on February 8th.

—△—

The Social Committee of The Medical Society of Milwaukee County held a meeting on February 2nd, to discuss entertainment during the social hour which follows the scientific meetings of the Society.

—△—

A meeting of the Educational Committee of the Medical Society of Milwaukee County was held at the executive offices on January 29th. Considerable discussion was given to periodic physical examinations and the educational program of the Society.

—△—

Mr. Theodore Wiprud, executive secretary of the Medical Society of Milwaukee County spoke at the annual conference of secretaries of the Minnesota State Medical Association at St. Paul on February 7th. His subject was "Experiences in County Medical Organization."

—△—

A meeting of the Child Welfare and Public Nursing Committee of the Medical Society of Milwaukee

County was held at the executive offices on January 22nd. Miss Kowalke of the Visiting Nurses Association was present and discussed some mutual problems with the committee.

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Dr. J. P. Fetherston presented a paper on "Tuberculous Peritonitis" at the staff meeting of Muirdale Sanatorium on February 17, 1931.

—△—

Mrs. Rose Carr Tisdale, mother of Doctor Louis Tisdale of Milwaukee died February 14th after a long illness. Mrs. Tisdale was 85 years of age and had been a resident of Milwaukee for many years.

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The engagement of Mary E. Marien of Belmont, Mass., to Dr. Arthur J. Patek, Jr., son of Dr. and Mrs. Arthur J. Patek, was announced in February. Dr. Patek is a graduate of Harvard Medical School and since his graduation has been studying in Munich. He will go to Cleveland in the near future to serve an interneship at the Lakeside Hospital.

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Dr. Wm. Jason Mixter of Boston, Mass., visited the home of Mr. and Mrs. Charles J. McIntosh during February.

—△—

Dr. J. P. Koehler, Commissioner of Health, announced the appointment February 19th, of four physicians on part time basis for ambulance service in connection with the new Johnston Emergency Hospital. The physicians appointed are Doctors Jerome Fons, Edward J. O'Neill, P. J. Niland and Frank S. Rybak. They work in shifts from 8 A. M. to midnight daily. After midnight their duties will be taken over by the regular hospital staff of three physicians. The newly appointed physicians will also assist in clinical work at the hospital.

This ambulance service was established following recommendations of the Medical Society of Milwaukee County.

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Dr. Samuel Plahner appeared before the Exchange Club of Milwaukee on February 12th. He spoke on "Human Nature." He also spoke at the Grand Avenue Congregational Church on February 1st. His subject was "Applied Psychology." On February 8th Dr. Plahner spoke at the Sunday Evening Club of the Unitarian Church on "Love and Marriage."

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The Milwaukee Executive Committee of the Inter-State Postgraduate Medical Association held a session at the Hotel Schroeder on February 5, 1931. The meeting was held to discuss further plans for the coming International Medical Assembly to be held in Milwaukee next October.

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The following health talks sponsored by the Wisconsin State Board of Health will be given over the Milwaukee Journal Station WTMJ by Theodore Wiprud, executive secretary of The Medical Society of Milwaukee County during March:

March 3. "Giving Our Bodies a Square Deal."
March 10. "First Aid for the Baby."
March 17. "Accidents Kill More than War."
March 24. "It Is Still Necessary to Guard Against Smallpox."
March 31. "Health Begins at Home."

The talks will be broadcast at 5:45 P. M.

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Dr. L. M. Warfield spoke to the Shorewood Cooperative Club on February 3rd. His subject was "What you should know about your heart."

—△—

Meeting of the Health Council of The Medical Society of Milwaukee County was held at the City Club on February 12th. Meeting was called to order by Dr. Ralph P. Sproule, chairman. In addition to the regular members of the Council the recently appointed representatives of the Hospital and Nursing Organizations were also on hand. Rev. Herman L. Fritschel represented the Hospital Superintendents Organization, Miss Jeanette Hays the Wisconsin Nurses Association, and Miss Erna Kowalke the Visiting Nurses Association.

Considerable discussion was given over to the health program of the Society. Following this discussion problems of hospital and nursing organizations as they relate to the medical profession were considered. The primary purpose of the first meeting of the enlarged Health Council was to present problems which confront various organizations which care for the sick in Milwaukee, and which might be solved by the Council. Meetings of the Council with representatives of various health organizations of the city will be held quarterly to discuss mutual problems.

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Over sixty members of The Medical Society of Milwaukee County have served at the Goodfellow House, the home for homeless and unemployed men sponsored by the Milwaukee Journal. The Society has assumed responsibility for physical examination of new men received at the House. Those found to be suffering from disease are referred to the County Dispensary for treatment. This service is under the direction of the Educational Committee of the Society. In the absence of Dr. R. W. Blumenthal, chairman of this committee, Dr. A. J. Patek is in charge.

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A series of discussions on child problems sponsored by the Journal Home Institute are being conducted by the Pediatrics Department of Marquette University School of Medicine and the Milwaukee Journal. Dr. M. G. Peterman is in charge. Those associated with Dr. Peterman and who are presenting discussions are: Doctors F. R. Janney, Alfred L. Kastner, A. B. Schwartz, H. O. McMahon, Karl E. Kassowitz and S. E. Kohn.

The first number in the series was given on February 13th. Six sessions will be held, one each week. All these meetings are open to the public.

BIRTHS

A son to Dr. and Mrs. Hans Reese, Madison, on January 26th.

A son, Donald Edwin, to Dr. and Mrs. J. Edwin Habbe, 1123 North 44th St., Milwaukee, on January 20th.

A son, John Richard, to Dr. and Mrs. A. F. Slaney of Hilbert on February 12th.

DEATHS

Dr. Daniel R. Connell, Beloit, died on February 8th in St. Anthony's Hospital, Rockford, where he had been confined as a result of a fall on January 25th when his left thigh was fractured.

Dr. Connell was born March 1, 1868, in Meeme township, Manitowoc County. Following his graduation from college, he taught school in Meeme for a number of years, later entering Northwestern University Medical School from which he graduated in 1891. He practiced in Chicago for a time, later establishing a practice in Davis, Ill. Since 1900 he was a practicing physician in Beloit. He was one of the founders of Beloit hospital and later he was instrumental in forming the Beloit General hospital.

He was a member of the Rock County Medical Society and the American Medical Association. He was also a member of the Beloit Physicians and Surgeons Club, and was a member of the staff of Beloit Municipal hospital.

He is survived by his widow and five sons.

SOCIETY RECORDS

New Members

J. A. Russell, 1280–27th St., Milwaukee.
R. D. Bergen, 1545 Layton Blvd., Milwaukee.
M. J. Reuter, 110–20th St., Milwaukee.
C. W. Osgood, A. O. Smith Corporation, Milwaukee.
A. D. Kilian, 215 Michigan St., Milwaukee.
John Hogan, Maiden Rock, Wis.
F. W. Kundert, 224 W. Washington Ave., Madison.
Paul R. Hahn, 1515 Washington Ave., Racine.
V. B. Mauricau, Stanley, Wis.
B. L. Schuster, Chippewa Falls.
C. F. Harris, Stanley, Wis.
R. J. Winkler, Insurance Bldg., Appleton.
G. M. La Croix, Shiocton, Wis.
Dennis H. Bruns, Watertown.
W. A. Joseph, 366 Greenfield Ave., Milwaukee.
J. B. Hitz, 425 E. Wisconsin Ave., Milwaukee.
L. C. Davis, Richland Center.

Change in Address

E. J. O'Brien, Oshkosh to 121 So. Maple Ave., Green Bay.
H. F. Beglinger, Oshkosh to Neenah.
C. T. Clauson, Bloomer to Galesville.

» » » CORRESPONDENCE « « «

TWO LICENSES REVOKED

WISCONSIN STATE BOARD OF MEDICAL EXAMINERS
Office of the Secretary
La Crosse, Wisconsin, February 10, 1931.

Mr. J. Geo. Crownhart,
State Medical Society,
Madison, Wisconsin.
Dear Sir:

On February 3, 1931, Dr. Fred C. Liefert was convicted of second degree manslaughter in municipal court of Milwaukee and in addition was sentenced to five years in the house of correction, the Honorable George Shaughnessey presiding judge.

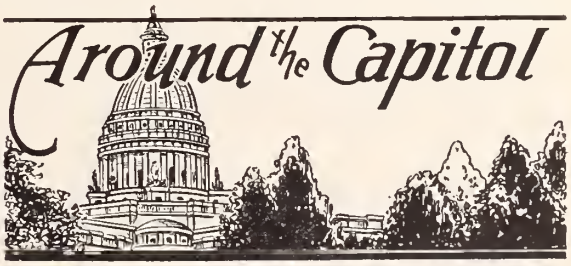
Judge Shaughnessey also ordered his license to be revoked.

Dr. Fred C. Liefert was graduated from Marquette Medical School in 1912, and was licensed by examination in our state on March 12, 1914. His license number was 4237.

On the report submitted yesterday we failed to report the revocation of the license of Dr. W. B. Parke, Camp Douglas, Wisconsin, whose license was revoked by the court of Monroe county on November 22, 1930, on a charge of manslaughter. He was sentenced to hard labor for not less than five years at Waupun. He was a graduate of Milwaukee Medical College. His license number was 2107, being licensed upon the basis of diploma on July 14, 1903. His license was also revoked by our board on January 13, 1931.

Very truly yours,
ROB'T. E. FLYNN, M. D.,
Secretary.

REF:VMG



Provisions of the will of Charles G. Stark, who died in Milwaukee, in 1908, and left $125,000 for the founding of a children's hospital, were held valid and enforceable by the Stark Hospital Corporation. That corporation was organized by Rev. Holmes Whitmore, of St. Paul's Church, of Milwaukee, and several other philanthropists of Milwaukee, in ac-

cordance with directions in Mr. Stark's will, to take advantage of the hospital bequest.

The will endowed two free beds in the hospital, which were to be known as the Sarah bed and the Lucy bed, in memory of Mr. Stark's widow, Mrs. Lucy Stark, and her sister, Mrs. Sarah Stark, who had been Mr. Stark's first wife.

When Mr. Stark's widow died in 1927, she also left about $200,000 to the hospital, which was to be erected. Since her death the Stark hospital has acquired land next to the Milwaukee Children's hospital, on which the new Stark Hospital will be erected and conducted in close co-operation with the present Children's Hospital.

In affirming Judge Karel's decision sustaining the bequest, the Supreme Court, in an opinion written by Chief Justice Rosenberry, held that the incorporators have devised a practical, workable plan which will prove of great advantage to the neglected and dependent children who may be its beneficiaries, and have done it in a way that will effectuate the wishes of the testator.

* * *

Incomplete reports show 790 deaths as the Wisconsin auto accident toll for 1930 as compared with 701 deaths for 1929, marking the startling increase of 11.3 per cent, it was announced by the bureau of vital statistics, state board of health.

More Wisconsin children under ten years of age were killed in auto accidents last year than in any previous year, the number being exactly 100 as compared with 93 in 1929, and it is pointed out by the bureau that the automobile is responsible for more deaths among children than all the communicable diseases combined.

* * *

Construction work on the new $100,000 addition to the student infirmary, and a $175,000 unit of the university horticultural building has been started, following the signing of contracts by ex-Governor Walter J. Kohler, just before the close of his term of office.

The new infirmary unit has been designed to more adequately care for the health of the students and will double the capacity of that building, incorporating several new modern features not found in the older section of the building.

Laboratories and small class rooms will occupy the greater amount of the space in the agronomy unit, and the exterior of the building will be done in the Renaissance style. Contractors plan to finish both units in about a year's time.

* * *

The tenth anniversary, this year, of the discovery of insulin by Drs. Banting and Best of Toronto, now universally used as a specific agent for the treatment of diabetes, will be observed in Wisconsin with a medical extension program aiming to extend knowledge of insulin and its scientific application among physicians of the state.

At the request of the State Medical Society, the University of Wisconsin has organized a one-day course on insulin and its use, to be given from May 18 to 23 in each of the following centers: Madison, Milwaukee, Oshkosh, Wausau, Eau Claire, and La Crosse. These classes will be organized by the field organization staff of the university extension division.

Dr. Leland S. McKittrick, Boston, Mass., and Dr. Russell Morse Wilder, University of Chicago, recognized authorities on insulin, will be brought to Wisconsin, and with Dr. E. L. Sevringhaus and a dietitian of the Wisconsin Medical School will impart newer knowledge of this subject through lectures and demonstrations for physicians enrolling.

* * *

Dr. Joseph L. Benton of Outagamie County versus Susan Stadler was a case which came up in the Supreme Court in which the Supreme Court decided that under the facts of this case the jury had a right to find that there was an implied agreement on the part of the father to pay the doctor for treating professionally an adult daughter, and affirms the judgment of the circuit court against the father.

* * *

Dr. C. A. Harper, veteran state health officer, will retain his position with Governor La Follette sending his name to the senate for confirmation. Ex-Gov. Walter J. Kohler reappointed him but it was an interim appointment. La Follette sending his name to the senate gives him another full term.

Reappointment of him, however, brought one dissenting vote in the senate when Sen. Cashman contended that the health department has been hurting the dairy interests. He said that the health department, by pointing out dangers in milk and urging pasteurization, is discouraging the use of milk and he voted against the Harper confirmation.

Dr. Gunnar Gundersen of La Crosse Succeeds Father on University of Wisconsin Board of Regents

Dr. Gunnar Gundersen, La Crosse, has been appointed by Governor LaFollette to be a member of the Board of Regents of The University of Wisconsin for a term of six years, expiring in 1937. Dr. Gunnar succeeds his father, Dr. Adolph Gundersen who declined reappointment to the Board. The new member of the Board is the representative of the medical profession of the state.

Dr. Gundersen graduated from the University of Wisconsin in 1917 and received his medical degree at Columbia in 1920. He is

a member of the State Medical Society committee on medical extension at the University.

In making the appointment, Governor La-Follette made public the following letter of appreciation to Dr. Gundersen, Sr., whose place his son now takes:

"Dear Doctor Gundersen:

"I want to express to you the deep regret every friend of the University of Wisconsin will feel on learning that you prefer not to be reappointed a member of the board of regents. Your ripe experience, your specialized training, your broad culture, and above all your splendid character have made a contribution to the regents it will be extremely difficult, if not impossible, to duplicate. At the same time I am confident everyone will be sympathetic with your desire to lessen the heavy burden of responsibilities you are carrying.

"I am certain I speak the united sentiment of the state when I gratefully acknowledge the years you have so generously given to the university and the state.

"It will be a source of deep satisfaction to all to know that, so far as possible, your spirit, character and ideals are to be continued on the board of regents through your distinguished son.

"With affectionate regard and respect,

"Faithfully yours,

"PHILIP F. LA FOLLETTE."

University Announces Special One-Day Insulin Programs for May

The tenth anniversary, this year, of the discovery of insulin by Drs. Banting and Best of Toronto, now universally used as a specific agent for the treatment of diabetes, will be observed in Wisconsin with a medical extension program aiming to extend knowledge of insulin and its scientific application among physicians of the state. At the request of the State Medical Society, the University of Wisconsin is organizing a one-day course on insulin and its use, to be given from May 18 to 23 in each of the following centers: Madison, Milwaukee, Oshkosh, Wausau, Eau Claire, and La Crosse. These classes will be organized by the field organization staff of the University Extension Division.

Dr. Leland S. McKittrick, Boston, Mass., and Dr. Russell Morse Wilder, University of Chicago, recognized authorities on insulin, will be brought to Wisconsin, and with Dr. E. L. Sevringhaus and a dietitian of the Wisconsin Medical school will impart newer knowledge of this subject through lectures and demonstrations for physicians enrolling.

Dr. McKittrick is a graduate of Harvard Medical school and is on the staffs of New England Deaconess hospital and Massachusetts General hospital. He was born and reared in Wisconsin, and took his pre-medical course at the University of Wisconsin. In 1929, collaborating with Root, he published "Diabetic Surgery."

Dr. Wilder, a graduate of the University of Chicago and of Rush Medical college, was associated for ten years with the Mayo clinic at Rochester, Minn., where he was head of one of its sections, and was professor of medicine at the Mayo Foundation, the graduate school of the University of Minnesota. Since May 1, 1929, he has been professor of medicine and chairman of the department of medicine at the University of Chicago. Medical journals are replete with scientific articles by Dr. Wilder dealing with diabetes.

Another medical extension course—obstetrics and medical gynecology—is planned for cities in northeastern Wisconsin. Beginning June 15, these meetings will be held once a week for 12 weeks at Marinette, Green Bay, Appleton, Oshkosh, Sheboygan, and Manitowoc.

These plans were adopted recently by three co-operating agencies—the State Medical Society, the Medical School, and the University Extension Division, represented by the following: Dr. Otho Fiedler, Sheboygan; Dr. G. Gundersen, La Crosse; Dr. J. F. Wilkinson, Oconomowoc; and J. G. Crownhart, for the Medical Society; Dean C. R. Bardeen, Dr. R. C. Buerki, Dr. E. L. Sevringhaus, and Dr. J. S. Evans, for the Medical School; and Dean Chester D. Snell, Chester Allen, and Nelson D. Conners, for the Extension Division.

Bills Affecting Medical Profession Reached as Legislature Starts Third Month of Session

Recommending the State Hospital Bill, 182, A, for passage and recommending killing for the anti-vivisection bill, 178 A, were the first legislative actions on the many bills affecting the medical profession that are now pending before both houses of the Wisconsin Legislature.

These recommendations, in accord with the position of the State Medical Society, were the unanimous vote of the Assembly Committee on Public Welfare following committee hearings on both measures on Wednesday afternoon, Feb. 18th. The State Hospital Bill, if passed, will modify commitments to the state institution to the extent that if the county judge feels that the needed treatment can be given within the county at a lesser county expense, he may order such treatment locally instead of sending the patient to Madison.

Anti-vivisectionists filing a petition of 5,250 names, failed to make appearance when the bill was called for its Assembly committee hearing. Assemblyman Zittlow, after explaining that he had introduced the measure at the request of the Wisconsin Anti-Vivisection Society, declared that he understood many proponents of the measure were to appear and was at a loss to explain why they were not there. The only appearance for the bill was made by Mr. William C. Dean of Madison, a legislative employe.

Opposition to the bill was opened by Mr. George Crownhart, Secretary of the State Medical Society, who outlined the entire proposition in general terms. Succeeding speakers discussed various phases of the subject matter for an hour and a half at which time the remaining speakers, rather than keep the Committee longer, simply registered their appearance with the Committee and filed brief statements of their positions. Those who made statements before the Committee were Mr. Crownhart; Dr. W. J. Meek, Assistant Dean of the Medical School at Madison; Dr. Harry Steenbock; Dean B. F. McGrath of the Marquette Medical School; Judge A. C. Backus, Regent of both the Universities of Marquette and Wisconsin and Mr. Walter C. Corrigan of Milwaukee. Those who filed appearance against the measure included Drs. Herwick, State Toxicologist; R. C. Buerki, President Wisconsin Hospital Association; and Mr. E. E. Parkinson, Secretary of the Wisconsin Dental Society.

ANTI-VIVISECTION BILL

Anti-vivisectionists received little comfort from the Assembly when their bill was reached on Wednesday, February 25th. Assemblyman L. S. Shauger (M. D.) stated that the measure struck at the very vitals of scientific progress and that no more pernicious bill had ever been introduced in the legislative halls.

"The bill was introduced by request of the anti-vivisectionists and none of those," said Mr. Shauger, "who were instrumental in proposing the bill had the temerity to appear for it at the committee hearing. I move that the bill be killed and ask for roll call."

The bill was then killed by a vote of 86 to 1.

CHIROPRACTIC BILL

Assemblyman Grobschmidt has introduced, by title only, a bill relating to the practice of Chiropractic. This measure will not receive a number until the bill proper is placed in the bill envelope. Pending that time, its contents are not known.

MEDICAL BOARD BILL

A bill introduced by Assemblyman E. M. Rowlands (Cambria) by request of the State Medical Society of Wisconsin would wipe out obsolete requirements on the Governor for appointments to the State Board of Medical Examiners. Under terms of the bill, which affects no present member of the Board, the osteopathic representation would be maintained as at present. Instead of the Governor being required to subdivide medical appointments, however, to make three non-sectarian, two homeopathic and two eclectic, the bill would provide "seven members licensed to practice medicine and surgery" in addition to the osteopathic member.

The State Medical Society points out that in the last ten years there have been but 8 homeopaths and no eclectics admitted to the state, as compared to 1,019 graduates of non-sectarian schools and that the Board of Medical Examiners no longer holds special examinations for the various schools of practice, except for osteopaths whose representation on the Board remains unchanged. There are no eclectic schools now in existence and the two remaining homeopathic schools, located in the East, are fully approved by the medical profession. Graduates of the old homeopathic and eclectic schools no longer practice exclusive systems of treating the sick, it is said.

Free Choice of Physicians Argued Before Assembly Committee

The substitution of free choice of physicians for injured employees under the workmen's compensation act as provided in Assembly bill 71 A, by Assemblyman Beggs of Rice Lake, was advocated before the Assembly Committee on State Affairs the second week in February. A report of the hearing on such points as were of particular interest to physicians follows:

Assemblyman C. A. Beggs, Rice Lake.—I view this wholly as a matter of justice. The bill allows the injured patient to select his own doctor and puts it up to the Industrial Commission as to the charges. The Industrial Commission is permitted, under the bill, to set up a list of charges. In my home town of Rice Lake there is a lumber company and I know that under the present law their employees are obliged to go to one doctor. One doctor gets the entire business and he is naturally interested in the company's angle rather than in the injured employees.

In the larger cities I understand that some of the companies employ nurses at their plant and injured men are taken care of by such nurses who should go to the surgeon, but the companies hold the club over the men of possible loss of positions.

I appreciate that much of this does not come to the notice of the Industrial Commission but I have many letters here from doctors and I am confident this bill will provide a better plan in the interest of justice.

Assemblyman John Gamper, Medford.—Have you had a conference with the Industrial Commission on this bill?

Assemblyman Beggs.—No, sir.

Assemblyman M. B. Goff, Sturgeon Bay.—I know that some employees have taken great advantage of the employer by having an unscrupulous physician build up the costs. It has resulted in taking some doctors from the panel. Shouldn't there be some protection afforded the company under this bill?

Assemblyman Beggs.—I have provided for supervision by the Industrial Commission which I think will be sufficient. I think there is a greater injustice to the employees under the present plan than to the employers.

Assemblyman J. C. Hanson, Deerfield.—Isn't this bill rather against the interests of the insurance companies?

Assemblyman Beggs.—My sympathies are with the working man and not some third party. I know that some workingmen now forego entering claims rather than take the chance of losing their job.

Assemblyman H. C. Malchow, Green Bay.—I note you say in the bill "his own physician." Do you mean that the injured employee can select his own medical physician or his own type of treatment?

Assemblyman Beggs.—I mean family physician.

Assemblyman Malchow.—Yes, but could that not be interpreted to mean chiropractors or osteopaths?

Assemblyman Beggs.—I intended to mean just M. Ds.

Assemblyman D. F. Burnham, Waupaca.—I think Mr. Beggs is right. Last night I was the guest of Dr. Ganser of Madison and I know that he is in favor of the bill.

THOSE AGAINST THE BILL

Senator H. E. Boldt, Sheboygan Falls.—I believe, Mr. Chairman, that the present arrangement is sufficient. If the Industrial Commission is not satisfied with the panel they can revise it. If you give the men the right to call their family physician I call your attention to the fact that the family physician may be miles away.

L. J. Parish, O. A. Smith Corporation, Milwaukee.—Under the present law the company is interested in securing permanent, efficient and adequate service for two main reasons—for humane reasons and because it costs less money. Adequate service tends to get the men back earlier and reduce the cost and lessens disability. There are all types of men in medicine as there are in any other profession. Naturally the specialist in industrial injuries is best qualified.

Under the present law, if the company fails to give competent and reasonable service such failure now allows the employee to secure free choice of physicians and if the panel physician has not impartially estimated the disability, the Commission has the power to send the employee to another physician and charge the cost to the employer. All right thinking employers are anxious to give their men the best possible service and if there are any who are not giving such service, the Industrial Commission now has the power to take care of them.

On the matter of the proposed fee schedule I think you will find it extremely difficult to set the fee for any type of case. I think the doctors may well object for every case is different from any other one.

I have two suggestions to make: (1) If the present law does not work out satisfactorily I suggest you increase the number on the panel. We have no desire to limit the panel to five,—it could just as easily be ten or fifteen. (2) You might well provide that employers must submit the panel list to the Industrial Commission for approval.

Assemblyman Malchow.—I am a lawyer at Green Bay and I know that under the panel system the company lawyers have the first opportunity to examine the injured employee. It puts the insurance company in a strategic position. I know as a positive fact that doctors have gone out of their way to help the insurance lawyers. I think the Beggs bill is a practical one and I would remind you, Mr. Parish, that there are corporation doctors as well as corporation lawyers who take every advantage of injured employees.

Mr. Parish.—But I maintain that there is no object in not giving a man good care.

Assemblyman Malchow.—Why not let the employee pick his physician?

Mr. Parish.—If I came to you as a friend in Green Bay and wanted some law business done, you would guide me where I could secure competent service for the peculiar type of work that had to be accomplished. That is all the companies would like to do. There are lawyers and lawyers and there are doctors and doctors. The average man has no way of determining those who are peculiarly competent to do the precise work that is needed in his individual case.

Assemblyman Malchow.—But suppose the man has a family physician in whom he does have confidence.

Mr. Parish.—A doctor may be a family physician and yet not handle surgery.

Assemblyman Malchow.—But the family physician would refer in such cases. At least the injured employee would have the opportunity of going to his family physician first.

Mr. Parish.—I am afraid, Mr. Malchow, that you are putting the good ones with the bad.

Assemblyman Burnham.—I think the Smith Corporation (self-insurers) presents a different case. There are companies in northern Wisconsin whose only interest is in getting the transient worker who may be injured off the list. I have in mind a case where there were gross irregularities and others where the injured employee was put on the town. There is quite a difference in the companies that employ floating labor.

Assemblyman Hanson.—You have an altruistic attitude, Mr. Parish, but I know that there are insurance companies who employ able lawyers who beat the men out of their compensation.

Mr. Parish.—We have no lawyers who appear before the Industrial Commission and I know that we are not the only company that does not use lawyers.

Assemblyman Malchow.—Couldn't we fix the present law so that the Industrial Commission could allow an examination by the family physician at no cost to the injured employee? That would help some.

Assemblyman C. B. Perry, Milwaukee.—The A. O. Smith Corporation has very harmonious relations with its employees. Do you think this bill would endanger such relations?

Mr. Parish.—No——

Assemblyman Perry.—Well, if the bill would not endanger your relations you will concede that it might do some good where the relations are not so harmonious.

Mr. Parish.—I would modify statement for under the terms of this bill the employees might go to the nearest doctor rather than the one who was the specialist and our newer employees, not familiar with the company's policy, might receive very inadequate treatment. We would rather pay $5,000 in preventive medicine and to secure adequate care than to pay $5,000 as compensation where the man will be permanently handicapped.

Mr. L. G. Fuhrman, Wisconsin Bridge and Iron Company.—I only want to enter an appearance against the bill. Injured men must be taken care of immediately and frequently we could not afford to wait for the family physician.

At the conclusion of the hearing members of the committee asked if there was representation of the Industrial Commission present. There being none the sentiment was voiced that such representation should be secured for the advice of the committee in its executive session before voting on the measure.

Medical Grievance Committee Bill Killed in Senate

Unexpected opposition to the Hunt bill opposing the establishment of a medical grievance committee as endorsed by the State Medical Society developed at its senate committee hearing on February third. Henry J. Staab, former assemblyman of Milwaukee, declared that this bill was a further effort to put a high wall around the medical profession and in closing voiced strenuous protest against the activities of the investigator for the State Board of Medical Examiners and urged the non-continuation of the appropriation. Senator Bernard Gettelman, Milwaukee, voiced the fear that the grievance committee would be overly concerned

(Continued on page 230)

PRESS SERVICE OF STATE MEDICAL SOCIETY

No serum does so much for public health as printer's ink

SINUS TROUBLE

Madison, Wis., Jan. 28—Ancients discovered that the nose was the seat of smelling but modern scientists have often found it to be a disease trouble maker. Sinus trouble, which affects many people at this time of the year, is a disease originating in the nose. People affected by frequent colds will probably discover that they are suffering from sinus trouble and that the cold is but a manifestation of the disease.

The Educational Committee of the State Medical Society declares that the greatest precaution should be taken by people suffering from occasional colds that the infection does not become general.

"Surrounding the nasal cavities are several hollow spaces in the adjacent bones which have natural openings into the nose," continues the bulletin. "These spaces are spoken of as the nasal sinuses. Normally they contain air and are lined with a continuation of the mucous membrane of the nose. The openings are of moderate size and designed merely for ventilation. When an infection develops in a sinus, there is difficulty in establishing sufficient drainage for the thick mucus and pus, hence it lies in the cavity and is absorbed.

"Therefore the nose and its associated sinuses may be the starting point of many systemic involvements. With one or more of the sinuses chronically infected, an absorption of the poisonous products may be conveyed to distant parts. Although a pain or ache, perhaps in an arm, indicates that a probable infection is present, yet to locate the focus or foci of infection is sometimes very difficult.

"Very often the starting point of an infection in one or more of the nasal sinuses is from a cold in the head associated with an attack of influenza. After about ten days of convalescence, but sometimes much sooner, a pain and aching develops over the cheek or the forehead and continues with increasing severity until the pent-up pus finds an outlet and there is a discharge of, more or less thick matter. This points to the need of drainage of the infected sinus. Sometimes the first attack may be the last but in many cases, owing to inadequate drainage, repeated attacks occur until finally the sinus becomes chronically infected. One of the characteristic features of this type of trouble is the so-called repeated cold. These patients complain of many colds in the winter. They state that they are no sooner over one than another comes along so that the fall, winter, and spring is just one cold after another.

"Most sinus sufferers complain of a dropping in the throat, of a heavy discharge from the nose when having a cold and some thick nasal secretion when the cold is absent. During an acute attack, there is headache over the eyes or aching (almost always spoken of as neuralgia) over the cheek or in the back of the head extending into the neck. The repetition of these symptoms during bad weather is very suggestive of an infection in one or more of the sinuses."

COMMUNICABLE DISEASES

Madison, Wis., Feb. 4—Communicable diseases are most common during the next three months, according to data which was recently compiled by the State Board of Health. At the present time, February and March are the months most to be feared. These are the months when there is the highest mortality due to the prevalence of communicable diseases such as measles, scarlet fever, and whooping cough.

The Educational Committee of the State Medical Society in a bulletin issued today warned people of the increased prevalence of pneumonia at this time of the year and gave a caution for special vigilance as to personal care.

"A good part of this bad record for February and March is due to the increased prevalence of respiratory diseases which have a high winter incidence particularly among young children and old people," declared the bulletin. "The death rate from pneumonia, bronchitis, pleurisy and other diseases of the respiratory system, tuberculosis excepted, is never high among people from five to fifty years of age as compared with the death rates among children under five, and especially children under one and old people. The death rate from these diseases gradually rises from November and usually reaches the highest peak in March or April. During January, February and March, as a rule, more people die from pneumonia and other respiratory diseases than die from these same diseases during the remaining nine months of the year.

"During years when influenza is not especially prevalent, we have from 325 to 350 deaths from pneumonia during each of the winter months, while during the months of July, August, and September we usually have less than 100 deaths per month from this one disease.

"Deaths from erysipelas are very common during the winter months. This is probably due to improper housing conditions which are favorable to the spread of the infection.

"There does not seem to be any seasonal variation in deaths from cancer, heart disease, or Bright's disease.

"There is a slight increase in the number of deaths from old age during the winter months.

"From a public health viewpoint, what can be done to further decrease the number of deaths during the winter months? The prevention of common colds, bronchitis and tonsillitis, and the proper kind of treatment for these ailments when they first appear will aid materially in preventing a great amount of serious illness and deaths resulting from respiratory diseases. Pneumonia, which is fatal to one out of every four or five people who get it, could be prevented in a large number of cases if the severe cold, which is usually one of the first symptoms, is properly taken care of."

HEART CONDITIONS

Madison, Wis., Feb. 11—Many of the signs which people think mean heart trouble can be traced to some disorder. Indigestion, lung trouble, or nervousness may cause pain near the heart, shortness of breath, fainting, and irregularity of beat.

The Educational Committee of the State Medical Society in a bulletin issued today declares that instead of worrying about heart conditions, most people should regulate their lives to remove the symptoms. The statement declares that many cases of heart trouble are curable and that all can be relieved by attention to personal habits.

"A child with a defective or weak heart should follow a carefully planned regimen," declares the bulletin of the Medical Society. "His school work, his play,

(Continued on page 230)

THE JOURNAL BOOK SHELF

The Medical Museum. By S. H. Daukes, M. D., director of the Wellcome Museum of Medical Research. An amplification of a thesis read for the degree of M. D., Cambridge. The Wellcome Foundation Ltd., 33 Gordon St., London.

Tropical Medicine in the United States. By Alfred C. Reed, M. D., Professor of Tropical Medicine, The Pacific Institute of Tropical Medicine within the George Williams Hooper Foundation for Medical Research of the University of California. J. B. Lippincott Company, Philadelphia.

Burns. Types, Pathology and Management. By George T. Pack, B. S., M. D., fellow of the Memorial Hospital, New York City; formerly professor of pathology and lecturer in minor surgery, The School of Medicine, University of Alabama; and A. Hobson Davis, B. S., M. D., instructor in pathology, University of Alabama. 60 illustrations. J. B. Lippincott Company, Philadelphia and Lonodn.

Handbook of Anatomy. By James K. Young, M. D., F. A. C. S. Revised by George W. Miller, M. D., F. A. C. S. Seventh Revised Edition. With 154 Engravings. Philadelphia, F. A. Davis Company, 1930.

Injection Treatment of Internal Hemorrhoids. By Marion C. Pruitt, M. D., associate in surgery, medical department, Emory University. Illustrated. Price $3.00. C. V. Mosby Company, St. Louis, 1929.

Hemorrhoids, The Injection Treatment and Pruritus Ani. By Lawrence Goldbacher, M. D., Philadelphia. Illustrated with 31 half-tone and line engravings. Price $3.50 net. F. A. Davis Company, Philadelphia, Pa.

Blood and Urine Chemistry. By R. B. H. Gradwohl, M. D., director of the Gradwohl Laboratories, St. Louis and Ida E. Gradwohl, A. B., instructor in the Gradwohl School of Laboratory Technic, St. Louis. With 117 illustrations and 4 color plates. Price $10.00. C. V. Mosby Company, St. Louis, 1928.

Episcopal Hospital Reports. Volume VI, commemorating the 75th year of the Hosptial of the Protestant Episcopal Church in Philadelphia. Press of Wm. J. Doran, Philadelphia, 1930.

Outline in Obstetrics for Nurses. By F. W. Rice, M. D., instructor in obstetrics, Iowa Methodist Hospital and Broadlawns General Hospital, Des Moines. Price $2.00. C. V. Mosby Co., St. Louis.

Legal Medicine and Toxicology. By Ralph W. Webster, M. D., published by W. B. Saunders Co., 1930.

Manual of the Diseases of the Eye. For students and general practitioners. By Charles H. May, M. D. Director and visiting surgeon, eye service, Bellevue Hospital, New York, 1916 to 1926. Thirteenth Edition, revised. With 374 original illustrations, including 23 plates and 73 colored figures. Price $4.00 net. William Wood and Company, New York.

BOOKS RECEIVED FOR REVIEW

Infant Feeding in General Practice. By J. V. C. Braithwaite, M. D., M. R. C. P. (Lond.), physician and physician in charge of Children Out-Patients, Leicester Royal Infirmary and Children's Hospital; late assistant physician Queen's Hospital for Children, London. Price $1.75 net. William Wood & Co., 156 Fifth Ave., New York, N. Y.

Ante-Natal Care. By W. F. T. Haultain, O. B. E., M. C., M. B., senior assistant obstetric physician and late special assistant to ante-natal department, Edinburgh Royal Maternity and Simpson Memorial Hospital. And E. Chalmers Fahmy, M. B. (Edin.), assistant obstetric physician and special assistant to ante-natal department, Edinburgh Royal Maternity and Simpson Memorial Hospital. Second edition. Price $2.25 net. William Wood & Co., 156 Fifth Ave., New York, N. Y.

Traumatotherapy. By John J. Moorhead, B. Sc., M. D., professor of surgery and director, department traumatic surgery, New York Post-Graduate Medical School and Hospital; surgical director, Reconstruction Hospital Unit; colonel medical officers reserve corps, U. S. Army. 574 pages with 625 illustrations. Price $7.00. W. B. Saunders Co., Philadelphia and London, 1931.

Modern Surgery. By J. Chalmers DaCosta, M. D., LL.D., F. A. C. S., Samuel D. Gross Professor of Surgery Jefferson Medical College, surgeon to Jefferson Medical College Hospital, consulting surgeon to the Philadelphia General Hospital, St. Joseph's Hospital and Misericordia Hospital, Philadelphia. 10th edition, revised and reset. 1404 pages with 1050 illustrations, some in colors. Price $10.00. W. B. Saunders Co., Philadelphia and London, 1931.

Chinin In Der Allgemeinpraxis unter Berucksichtigung Pharmakologischer Befunde. By Dr. Med. Fritz Johannessohn. On demand, copies will be sent to medical men free of charge. Address, Bureau For Increasing the Use of Quinine, P. O. Box 215, Amsterdam-W, Holland.

Modern Methods of Treatment. By Logan Clendening, M. D., professor of clinical medicine, lecturer on therapeutics, medical department of the University of Kansas. Fourth Edition. Price $10.00. C. V. Mosby Company, St. Louis, Mo.

Cancer. Its origin, its development and its self-perpetuation. The therapy of operable and inoperable cancer in the light of a systemic conception of malignancy. A research by Willy Cather, M. D., consulting surgeon to the Lenox Hill and Postgraduate Hospitals, New York Infirmary for Women and Children, etc., emeritus professor of surgery, N. Y. Postgraduate Medical School. Price $7.50. Paul B. Hoeber, Inc., New York, N. Y.

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BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Secretary, Mr. J. G. Crownhart, 119 E. Washington Ave., Madison, Wisconsin. These new books will be loaned for an inspection period only.

Clinical Obstetrics. By Paul T. Harper, Ph. B., M. C., Sc. D., F. A. C. S. Fellow of the American Association of Obstetricians, Gynecologists, and Abdominal Surgeons, and of the New York Obstetrical Society. Clinical Professor of Obstetrics, Albany Medical College. Regional Consultant in Obstetrics, New York State Department of Health. Illustrated with 84 plates of engravings (250 figures) with legends and charts. Philadelphia F. A. Davis Company, Publishers, 1930.

It is very apparent that the author in writing this text did not intend that it should be used as a reference book for the general practitioner or medical student. He puts forward his personal ideas of the handling of obstetrical problems with no reference to other obstetrician's ideas or methods. Consequently this edition can be used best in a supplementary manner.

The text is well written and is printed in large easily readable type. There are over six-hundred pages of practical obstetrics without repetition or overlapping of subjects. It is illustrated by means of eighty-four pages of illustrations. The majority of these pages carry from one to six illustrations with complete legends. All illustrations are apparently original by the author and almost without exception diagramatic. Some of the illustrations are not readily comprehensible and so necessitated unusual concentration.

Embryology, histology, and pathology have been given very little, if any, consideration. The absence of the first two subjects are not missed, but it seems that at least some pathology should be included under abnormal obstetrics.

The reviewer feels that the author has taken a step in the right direction in offering a text book of this type. At the present time most obstetrical texts are too voluminous, and as a result confusing to the student. Let us hope that this author, or some other writer, grasps the same ideas and principles, and as a result is able to produce a teaching text even more suitable than the ones at present available. R. S. C.

Insomnia. By Joseph Collines, M. D. Price $1.50. D. Appleton and Company, New York.

In 126 pages, Dr. Collines has covered the subject of insomnia and disorders of sleep in such a manner that one cannot help but remark favorably upon his book. He has treated the subject in a very simple common-sense manner in the light of our present scientific knowledge regarding sleep and its disorders. He has written in a manner that is attractive to the layman and instructive to the physician. Physicians faced with the management of insomnia will find it a book that they can use as a therapeutic agent and prescribe its reading to their patients. J. L. G.

Practical Psychology and Psychiatry. By C. B. Burr, M. D., Sixth edition. Price $2.75 net. F. A. Davis Co., Philadelphia, Pa.

The sixth edition of Burr's "Practical Psychology and Psychiatry" brings up the contents of his previous editions in the light of our present knowledge regarding nervous disorders. This text is suitable for those interested in gaining a preliminary knowledge of the subject but almost too brief to be used as a text book for medical students and practitioners. The book is nicely arranged and edited. J. L. G.

Clinical Laboratory Methods. By Russel L. Haden, M. D., Professor of Experimental Medicine, University of Kansas, School of Medicine. Third edition. Price $5.00. C. V. Mosby Company, St. Louis, 1929. The volume covers the field of technical laboratory methods in a very concise yet thorough manner. The author chooses to present only one method for each test and has chosen, in each instance, the method that represents the most advanced and still widely accepted procedure. The technical detail is described in simple, excellent form that obviates numerous difficulties for the student or beginner. The material is well indexed and the text readily lends itself to be used as a complete laboratory manual.

The fact that the book is in its third edition is of itself sufficient proof of its merits. E. L. T.

Diseases of the Digestive System, Volumes I and II. By L. Winfield Kohn, M. D., F. A. C. P. Formerly assistant in the gastro-intestinal clinic, Johns Hopkins Hospital; chief of the clinic of gastro-enterology, Medico-Chirurgical College, Philadelphia; present chief of the gastro-intestinal clinic, Lebanon Hospital, New York City. Illustrated with 542 engravings, including 7 full page colored plates. Price of two volumes $12.00 net. F. A. Davis Company, Philadelphia, 1930.

We had hoped that when a new work on this subject appeared it would not conform to the old style books but would strike out along new lines. In this we are disappointed. The book is written along conventional lines with some of the newer methods described. For example, intragastric photography is treated in a short section composed mostly of reproductions of cuts of instruments and of photographs of views of lesions in the stomach taken with the camera.

The section on Bile might have been written ten years ago. No mention is made of the researches of Mann and his co-workers or of the work of Whipple and his collaborators. On page 75, Vol. I, the bare statement is made that, "Bile is a product of the liver cells and of the epithelium of the bile channels, particularly the gall bladder."

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Under the section of "Treatment" the author figures and describes the method of high colonic flushing with the specially devised Schellberg table and instruments. Possibly this may be good treatment but it savors a bit of charlatanry.

The two volumes of about 1100 pages are divided into twenty-three chapters. The author has attempted to cover the whole field of the digestive system from the mouth to the rectum with side excursions into endocrinology and sketchy descriptions of every disease which can or does produce reflex gastric or intestinal symptoms.

Chapters are devoted to dietary considerations and therapeutic considerations. In the former are listed diets for every disease of the gastro-intestinal tract. In the latter are twenty pages of prescriptions for the various diseases. These chapters may be helpful to many students of medicine and physicians.

A brief chapter on "Surgery of the Gastro-Intestinal Tract" by Dr. Zachary Cope, and a very complete index close the text.

On the whole this rather voluminous work seems somehow elementary. As one reads it one has a sense of inadequacy in the text. The volumes are well printed, the illustrations are numerous and help to elucidate the text. We do not think that the work is an improvement on other books dealing with the same subject. L. M. W.

Chronic Arthritis and Rheumatoid Affections. By Bernard L. Wyatt, M. D. F. A. C. P., director, The Wyatt Clinic; formerly associate director, The Rockefeller Commission to France. Price $2.50. William Wood & Company, 156 Fifth Ave., New York.

Wyatt points out the numerous classifications of arthritis that have been proposed at various times in various countries but with no general acceptance of any of them. The relationship of the condition known as acute rheumatic fever to heterogenous forms of rheumatoid and chronic arthritis condition is not settled. The term arthritis implies a chronic disease about a joint or in a joint. To regard it as anything other than a local symptom of an underlying systemic condition of the body is to miss its significance.

Disregarding all controversial considerations, arthritis may be divided into two classes that which results in true bony ankylosis and that which does not.

Lumbago, wry neck, neuritis, neuralgia, sciatica, etc., are in reality inflammatory changes and reactions in the white fibrous tissue and may be grouped under the term fibrositis and are now known to be the result of the same primary and secondary causes that have been noted in connection with the three clinical types of joint disease, i. e., (1) Infectious. (2) Degenerative. (3) Metabolic. From the standpoint of joint changes one is proliferative in character and usually infectious in origin; the other is degenerative and is rarely due to infection but to the injuries. Chronic metabolic arthritis (gout) is never of infectious origin, is degenerative in type and is generally attributed to a disturbed purin metabolism.

The program of prevention includes the maintenance of good muscle tone. Overeating is associated with the degenerative type, as is underweight with the infectious type. A healthy skin is a potent factor. Fatiguing occupations and poor posture are contributing agents. Early diagnosis is of tremendous importance. Delay may bring prolonged suffering. When taken in time there are few conditions that respond more promptly and satisfactorily. Food stuffs containing vitamin B are particularly recommended. Instinctive selection of food is not devoid of merit. No single drug has been demonstrated to possess a selective curative influence; autogenous and stock vaccines and non-specific proteins in selected cases in combination with other appropriate measures may be useful. Warm atmosphere is of the greatest importance. Whether hydrotherapy, electric currents or radiant heat be employed, it is the basic element. The importance of joint exercise should not be overlooked in prevention and treatment. It is probable that climate and sun baths will play a role of increasing importance. Heliotherapy is both an agreeable and effective way of stimulating the natural curative forces of the body. L. D. S.

A Compend on Bacteriology. By Robert L. Pitfield, M. D., attending physician, Germantown Hospital, Philadelphia. And Howard W. Schaffer, M. D., pathologist to the Memorial Hospital, Philadelphia; fifth edition, 82 illustrations and 4 plates. Price $2.00 net. P. Blakiston's Son & Co. Inc., 1012 Walnut St., Philadelphia.

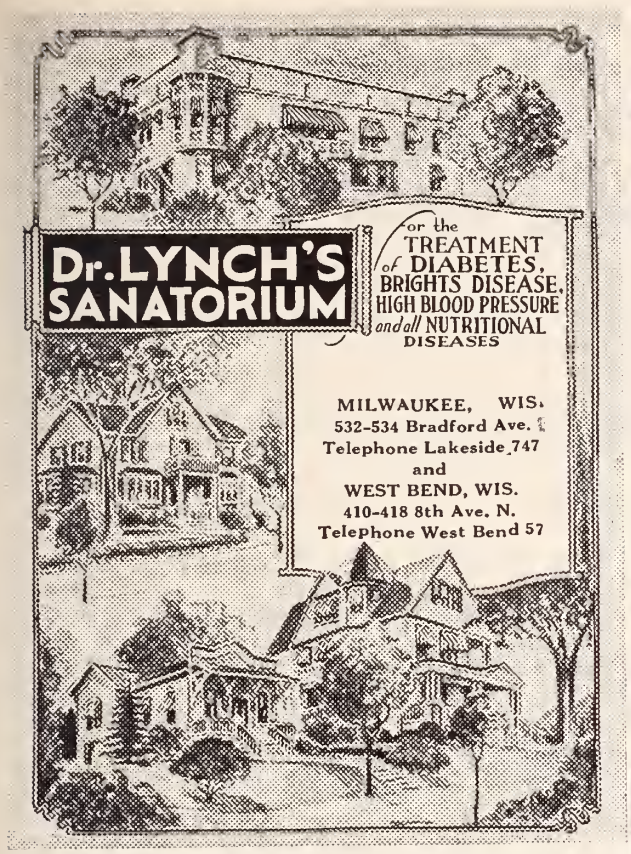
A book for students preparing for examinations, and a handy reference seems to be the raison d'etre of this book. Unfortunately, the reviewer is not very sympathetic towards compends. It seems to him that there are a sufficient number of them on the market. However, so far as compends go, this book certainly can be recommended. N. E.

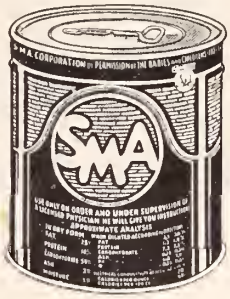
Treatment of Epilepsy. By Fritz B. Talbot, M. D., clinical professor of pediatrics, Harvard University Medical School; chief of Children's Medical Department, Massachusetts General Hospital. Price $4.00. Macmillan Company, 60 Fifth Ave., New York, 1930.

I consider this work a thorough treatise of the subject, written by a very capable author, and deserving of a place in any modern medical library. S. S. S., Jr.

A Manual of Normal Physical Signs. By Wyndham B. Blanton, B. A., M. A., M. D., assistant professor in medicine, Medical College of Virginia. 2nd edition. Price $3.00. C. V. Mosby Co., St. Louis, 1930.

This book gives you in as complete and short a form, all of the valuable points of Normal Physical





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Signs. It is easily understood, and easily referred to, well printed, and as a text book, I should judge would be of great value in certain classes. F. A. T.

Physical Diagnosis. By Warren P. Elmer, B. S., M. D., associate professor of clinical medicine, Washington University, and W. D. Rose, M. D., late associate professor of medicine in the University of Arkansas. With 337 illustrations. Price $10.00. C. V. Mosby Company, St. Louis, 1930.

This book is condensed into a text book size, is very well illustrated, and the material is very well arranged. The subject matter is well brought up to date, and an honest effort has been made to give in one volume the principal methods and facts of physical diagnosis. This book should be of value in a classroom for teaching purposes. F. A. T.

Doctors and Specialists. A medical revue with a prologue and a good many scenes by Morris Fishbein, M. D., editor of Journal of the American Medical Association and Hygeia. Price $1.00. The Bobbs–Merrill Company, Indianapolis.

Dedicated to the doctor with a sense of humor, this book is full of a humor sometimes ribald, certainly pointed, but like all humorous works it depends upon the unusual and the exaggerated for its effect. One would be happy to be able to say that it was a burlesque, if it were not for the fact that there is enough truth in it to sting. To those who have a sense of humor, and to those particularly who see in their own lives humorous situations, this book can be recommended to give a thoroughly jovial half hour. N. E.

Microbiology and Elementary Pathology. By Charles G. Sinclair, B. S. M. D., Major, Medical Corps, U. S. Army. Instructor in bacteriology, Army Medical School. With 102 illustrations, some in colors. Price $2.50 net. F. A. Davis Company, Philadelphia, 1931.

The reviewer finds very little to comment on. The book has been written in simple style. It is nicely illustrated, printed and bound. The information in the book is, of course, limited, but would seem to cover all the necessary requirements for nursing education. The only comment the reviewer has to make is that the book sells for $2.50, and a book of the same size, printing and binding, and containing about the same number of illustrations, written for physicians, would probably sell for almost double. Why? N. E.

Doctor and Patient. By Francis W. Peabody. M. D., Professor of Medicine, Harvard Medical School, director of Thorndike Memorial Laboratory, visiting physician and chief of the fourth medical service, Boston City Hospital 1921 to 1927. Price $1.50. The Macmillan Company, New York.

The reviewer has read many of the belles-lettres of medical literature, and is familiar with the standard classics. He has never read anything superior to these three essays from the pen of the late Dr. Peabody. Just as in his day Osler's writings and the essays of Sir Clifford Albutt and Sir Humphrey Rolleston were recommended. and just as in these writings Sir Thomas Browne's "Religio Medici" and other classics were recommended as stimulating, so the reviewer recommends this little volume to every physician whose soul and mind has not been too warped and dried by the toil and moil of practice and economic distress. There is a flavor to it that one hesitates to call philosophical, because the philosophical so often implies the impractical, but if ever three essays were written that contained a practical, working philosophy, that were full of sound advice and of vision and idealism, then these of Dr. Peabody's may be so characterized. Older practitioners and teachers could do no better than to give this book to their disciples. N. E.

Text-Book of Medicine. Edited by Russell L. Cecil, M. D., assistant professor of clinical medicine in Cornell University; assistant visiting physician in Bellevue hospital, New York City. Associate editor for diseases of the Nervous System, Foster Kennedy, M. D., professor of neurology in Cornell University. Second edition, revised and entirely reset. 1592 pages. W. B. Saunders Company, 1930. Cloth $9.00.

This book is a surprise to one who expects medical text books to be about ten years in arrears. The bibliographics appended to each article prove that the authors have followed the recent journals closely and should stimulate the reader to wider study. A further feature of importance is that many of the contributors are unquestioned leaders in their particular fields, such as Lawrason Brown on tuberculosis, Lewellen F. Baker on epidemic encephalitis, Thomas R. Brown on diseases of the stomach, Joseph C. Aub on lead poisoning.

The practical value of any scientific book is measured by the completeness and accuracy of its index. By this criterion the book is of a high order, because even such an unusual and only recently discussed subject as agranulocytic angina is well indexed and adequately considered. In fact on this subject, as on many others, the book is superior to many of the larger systems of medicine.

However the encylopedic nature of the work which makes the book of value to the internist as well as to the general practioner is the more remarkable in that it is presented in a single, very readable volume. E. L. B.

Normal Facts in Diagnosis. By M. Coleman Harris, M. D., lecturer on physical diagnosis, New York Homeopathic Medical College and Flower Hospital and Benjamin Finesilver, M. D., lecturer on diseases of the nervous system, New York Homeopathic College and Flower Hospital. Illustrated with forty-two engravings, some in colors. Price $2.50 net. F. A. Davis Company, Philadelphia.

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An interesting book on elementary diagnosis,—therefore of value only to students taking their first course in physical diagnosis. J. J. P.

Intestinal Toxemia. By Anthony Bassler, M. D., F. A. C. P., consulting gastroenterologist, St. Vincent's, Peoples' and Jewish Memorial Hospitals, New York City; St. John's Hospital, Yonkers; Christ Hospital, Jersey City. Illustrated with 16 text cuts. Price $6.00. F. A. Davis Company, Philadelphia, 1930.

The subject is very completely covered from every angle in this carefully written text. It is concise and yet omits nothing which would interest those in all branches of medicine. J. J. P.

The Treatment of Fractures. By Lorenz Böhler, M. D., Chief Surgeon and Director of the Vienna Accident Hospital. Authorized English translation by M. E. Steinberg, M. S., M. D., of Portland, Oregon. Formerly senior officer on the surgical service of the U. S. Public Health Service Hospital, and consultant surgeon to the U. S. Veterans' Bureau at Portland, Oregon. With 234 illustrations. Vienna, Wilhelm Maudrich, 1929.

This is a 185-page book covering the fractures of bones. It is filled with valuable material for the treatment of all varieties of fractures of every part of the skeleton.

On beginning a review of the book the reviewer is struck with some odd statements in the Translator's Preface to the English Edition and the Author's Preface to the German Edition.

The first sentence of the Translator's Preface reads as follows:

"I have observed Primarius Böhler's work at the Vienna Accident Insurance Hospital periodically for the last sixteen months and have also been given the privilege to use his methods personally."

The use of the word "privilege" is most unfortunate in a Translator's Preface of a foreign edition of a book on surgery. The idea back of this word privilege is quite in line with the advertising and business methods of foreign chemical manufacturers and is so childish in its use in connection with the surgical treatment of fractures, that one is impelled not to read further.

The reader is not less antagonized when he finds that the author in his Preface to the German Edition has indulged in a quantity of self praise that is quite out of place in a serious work covering the science and art of the treatment of fractures. The author weakens his influence by going into details regarding his experience, and his qualifications for writing the book.

However, the author's reputation as a mechanical surgeon and a teacher in the field of traumatic surgery reaches us in advance of his book and we proceed with the reading. There is no doubt that the author has brought together in fewer than two hundred pages a vast amount of information that has been in the books a dozen or a hundred years. He has reworked this literature, presenting it in classified, readable form covering practically the entire field of fractures in a better way and in less space than the subject has ever been presented before.

Positively, I can not find anything new in the book that is good. I do not look upon this as a shortcoming.

The text and the illustrations in the skeletal traction treatment of both long and short bones is extraordinarily interesting. They demonstrate that the author is a mechanical genius. His influence is destined to have a vast effect on the treatment of fractures. In the hands of competent careful surgeons, it will reduce deformity and disability. In the hands of the occasional surgeon and the one whose training is casual, whose experience is limited, and whose judgment is defective, the popularization of skeletal traction will bring incomparable disaster to thousands. We may expect a craze in this method of treatment of fractures like the craze following Lane's opera bouffe methods in popularizing open reduction of fractures and the use of non-absorbable internal splints. The Lane plate is a curse to the human race and skeletal traction can become the same sort of thing. Up to now the occasional surgeon has been afraid of skeletal traction. We may now expect him to enter this field for "fee and fame," and God help the injured. Osteomyelitis and cripples will be the harvest.

I can recommend Dr. Böhler's book on treatment of fractures to surgeons. They will find in a small book practically all of the useful mechanical devices in the treatment of fractures. The enthusiasm of the author for some forms of treatment must be tempered by the application of a critical judgment. E. Q.

Allergic Diseases. Their diagnosis and treatment. By Ray M. Balyeat, M. D., F. A. C. P. Director of the Balyeat Hay-Fever and Asthma Clinic, Oklahoma City. Illustrated with 87 engravings, including 4 in colors. Third edition, revised and enlarged. Price $5.00 net. F. A. Davis Company, Philadelphia.

In this volume the author takes up the subject of hay fever and asthma in a non-technical way so that this book is easy to read for the doctor or the patient. The discussion of asthma and hay fever is taken up from the allergic point of view. Newer methods of determining the cause of some allergic conditions other than hay fever and asthma are discussed in this volume. Although there is considerable attention given to diagnosis, the most important parts of the book are the chapters on treatment. Numerous pages are taken up with the discussion of characteristics of pollens of various plants. He discusses the factors which act in conjunction with the pollens in producing attacks of hay fever, asthma and other allergic diseases. The food factors in relation to all diseases are gone into rather thoroughly. Some case records are presented

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed care Wisconsin Medical Journal.

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with the discussion of the main points of the record. This is an important book. It is well written and it is very interesting as well as instructive. It is a well worth while book for every practitioner of medicine. F. D. M.

Grow Thin on Good Food. By Luella E. Axtell, M. D. 12Mo, Cloth. 344 pages, illustrated, indexed. Price $2.00. Funk & Wagnalls Company, New York.

The objection of this book is to put before the public a simple, accurate and practical presentation of the subject of food values. The author offers this information in an interesting manner and in such a way that the reading public as well as her professional brethren will enjoy it. Erroneous ideas about reducing are emphasized and "quack" formulas for growing thin are exposed. The reader is informed concerning the safety measures in dieting. Food value tables and menus are given and clearly interpreted. A chapter on tricks in cookery is included. This book is not a scientific treatise on diets but it is an interesting book on the subject of obesity. It should attract the attention of both the profession and public. F. D. M.

How it Happened. By Adalbert G. Bettman, M. D. Price $1.00 net. F. A. Davis Co., Philadelphia.

Dr. Bettman has launched a book of free verse upon the long suffering public. The subject matter is entirely concerned with disease; the neglect of early symptoms and particularly the results of venereal disease. The facts are obvious but the presentation of them is offensive to good taste. It is undoubtedly true that Dr. Bettman's purpose is to inform the public of certain important facts. Those facts, as he presents them, are well known to intelligent persons; however, they are beyond the grasp of the uneducated.

The function of poetry should not serve the ends of a medical treatise. But my quarrel with this book of verse is not its subject matter but the manner in which it is handled. The value of the great truths it contains is apparent to the slowest mind, but truth can be combined with beauty. To neglect the value of an appeal to the spiritual qualities is to throw away the staff upon which even the strongest pilgrim leans. Idealism awakens a surer response from humanity than vulgarity. The regeneration of the world will come, if it ever does, through truth presented simply and reverently. R. C. B.

Abdomino-Pelvic Diagnosis in Women. By Arthur John Walscheid, M. D., Director of Obstetrical and Gynecological Department of Broad Street Hospital; Director of Obstetrical and Gynecological Department of Pan-American Medical Center and Clinics, New York City; Consultant in Gynecology and Obstetrics to Margaret Hague Maternity Hospital, Jersey City, N. J.; Consulting Gynecologist to Bergen County Hospital, Ridgewood, N. J.; Consulting Gynecologist to the F. Reuter Home, North Bergen, N. J.

The physician who has survived the test of time is he who makes a diagnosis on careful clinical observations, and uses the laboratory only to confirm his clinical findings. Opportunities for clinical research are greater today than they were a century ago.

The large number of clinical departments on a full time basis, and well equipped laboratories for research work has stimulated the young clinician to engage in animal experimentations.

Lord Moynihan, in his recent address at the opening of the Banting Institute in Toronto, called attention to the neglect of research on man ("hominal research").

Walscheid's "Abdomino-Pelvic Diagnosis in Women" represents his own clinical experiences. It shows careful observations and a logical arrangement throughout, and may be read with profit by all those interested in abdominal diagnosis. W. J. C.

Operative Gynecology. By Harry Sturgeon Crossen, M. D., F. A. C. S., professor of clinical gynecology, Washington University School of Medicine; gynecologist in chief to the Barnes Hospital and the Washington University Dispensary. And Robert James Crossen, M. D., instructor in clinical gynecology and obstetrics, Washington University School of Medicine. 4th edition. 1246 illustrations and 2 color plates. Price $15.00. C. V. Mosby Co., St. Louis, Mo.

The vital question which now affects gynecology is this, is she destined to live a spinster all her days? For we see her on the one hand courted by her obstetrical ancestor, who seeks to draw her once more into an unholy, unfruitful alliance, destined to rob her of virility, to be rocked into innocuous desuetude for the rest of her days in the obstetric cradle, sucking the withered ancestral finger in the vain hope of nourishment (with apology for mixed metaphor).

On the other hand, we see her wooed by a vigorous, manly suitor, General Surgeon, seeking to allure her from her autonomy into his own house, under his own name obliterating her identity." Howard A. Kelly. History of Medicine by Garrison. 1924; P. 652.

Since the first edition appeared in 1915, it has been a popular reference book. With each edition, much new material has been added due to the disappearance of the imaginary line—iliopectineal line—separating gynecology from abdominal surgery.

The fourth edition has been completely rewritten and four new chapters added: Genital Fistulae (Chapter V); Diseases of the Urinary Tract in Relation to Pelvic Surgery (Chapter XVI); Disease of the Intestinal Tract in Relation to Pelvic Surgery (Chapter XVII); and Anesthesia in Gynecologic Surgery (Chapter XXII): with three hundred fifty nine new illustrations giving it the appearance of a text on abdominal surgery.

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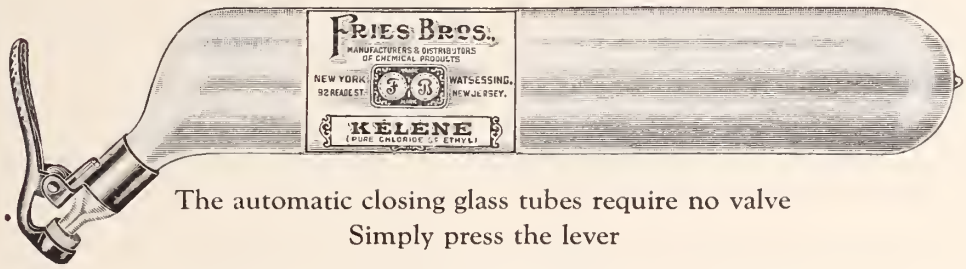

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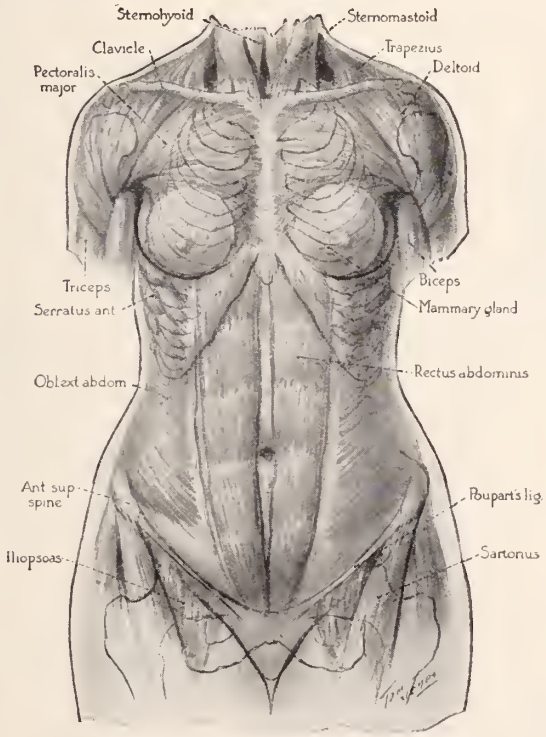

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As Deaver, (The Renaissance of Abdominal Surgery, The Passing of the Gynecologist. A. J. of Obs. & Gynec., 1924, 7, 299.) states that in the accepted sense of the term, neither the abdominal surgeon nor the gynecologist is a specialist but sees in the not distant future a realignment of surgery, and in the picture which rises he fails to see any one of the nomenclature of a gynecologist.

Expediency in surgery just as in all processes of evolution demands that those only survive who are capable of dealing with that larger field which lies between the diaphragm and the levator ani.

Dr. Crossen, being a student of physiology and pathology, has written this book on the dictum that: conscientious service to the patient requires that the selection of the type of operation be based on three considerations: a. Removal of effective palliation of the lesion: b. Minimum danger to the patient (mortality, morbidity) and, c. preservation of function.

It is an excellent reference book for the advanced student of surgery. W. J. C.

A Text-Book of Gynecology. By Arthur Hale Curtis, M. D., professor and head of the department of obstetrics and gynecology, Northwestern University Medical School; chief of the Gynecological Service, Passavant Memorial Hospital, Chicago. 222 original illustrations. W. B. Saunders Company, Philadelphia and London, 1930.

The author first gives a very thorough presentation of the infectious processes most commonly encountered in gynecological practice. He then presents two sections on tumors of the uterus and ovary. Following this, there are two large divisions on displacements and relaxations and disturbances of function and then a discussion of gynecological diseases and symptom complexes. The final section discusses examination, diagnosis of early pregnancy, gastro-intestinal and urinary tracts, radiotherapy, anesthesia, operative management and post operative care.

The volume is small but is a concise and complete presentation of the author's personal experiences almost without reference to other books.

There are 222 original illustrations which are very instructive and well arranged.

This is truly a remarkable book and unusually practical. A. H. L.

MEDICAL LIBRARY SERVICE

AROUND THE LIBRARY

Probably the library is a rather hazy memory for many doctors whose active practice has absorbed most of the realities of medicine, but we hope that the haze is a friendly one and not in the least impenetrable when leisure or the occasion suggests further uses for any resources with which we can be of service to you.

Those who have not visited the library since its removal to the Service Memorial Institute have a real surprise in store, for it has expanded from its one small hospital room, and consolidated from its housing in the general and departmental libraries until it now has become a department in itself composed of the Medical Library Service and the Medical School Library. The Medical School Library occupies a large room on the first floor facing on North Charter Street as well as a corresponding stack room in the basement. The text and general reference books occupy nine double stacks in the reading room, another single stack is almost completely filled with indices and encyclopedias, while the current journals are arranged alphabetically by title along the rear wall. The bound journals and, as a concession to the ever growing demand for space in the reading room, the gift collections are shelved in the basement. Wall tables in the basement and six large reading tables on the first floor provide ample space for the readers; although examination time finds all available space crowded.

But interesting as the library may be of itself, the hurried visitor will undoubtedly receive more of its true spirit from the displays which he sees in the exhibit cases in the center of the Memorial Room. These displays are planned or supervised by various faculty members, and have elicited many complimentary remarks and discussions. One of the first of these exhibits was centered on Pathology. From one of the notes we read that "Morgagni acknowledges his debt to Bonet's monumental work"; this work was a compilation of the postmortems of the XVI and XVII centuries, and a translation and continuance of Nicholas de Blegny's *Nouvelles Decouvertes sur Toutes les Parties de la Medicine*. Then there were copies of some of Morgagni's books, and a short summation of his work. From this brief sketch we learn that he was the first to describe "cerebral gummata," and also of his correlating postmortem findings and clinical records. Other points might be noted, but we can give each but a hurried glance. There was a photograph of Matthew Baillie who, in 1793, published the first Morbid Anatomy. Rokitansky was represented by Swans' translation of the third German edition of his Pathological Anatomy. It is interesting to note that the library has since secured a first edition of the German text which was published between the years 1842 and 1846. This work is based upon his postmortem findings of which the total for his life work is said to be over 30,000. Another professor of the Vienna School, Josef Skoda, who is to be remembered for his work on percussion and auscultation was represented by Sternberg's biography in the *Meister der Heilkunde* series. Then, there was a photograph and book display for that broad cultured founder of modern pathology, Rudolf Virchow. One of his pupils, Julius Cohnheim, was also included in the exhibit

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because of his "brilliant contributions to the study of nerve endings through his introduction of freezing fresh preparations, and the use of gold and silver salts." His monographs in German on "inflammation and suppuration" were shown. This Pathological Exhibit was concluded with the display of some of Weigert's books which deal with the pathological anatomy of smallpox and Bright's disease and the staining of bacteria and nerve tissues with anilin dyes.

Later, there followed an exhibit on the historical high lights of Bacteriology. Reference was given to the short sketches of Leeuwenhoek, the first recorded user of a microscope, in Locy's *Biology and its Makers* and in Garrison's *History of Medicine.* Sinclair's *Semmelweiss: His Life and Doctrine* was referred to as a biography for the noted pupil of Skoda and Rokitansky, Ignaz Philipp Semmelweis, whose observations led him to conclude "that the cause of 'child bed fever' was carried on the hands of examining physicians and students from one case to the next," and who, therefore, introduced "the use of antiseptic hand washes." Due homage was paid to Koch and Pasteur, the founders of the science of Bacteriology, but no mere words here can fully praise or even note their epoch-making contributions. The work of Lister on antisepsis and asepsis was also honored; his *Collected Papers* have been published in two volumes. Nor was the Amercian, Oliver Wendell Holmes, who is often listed by literary people as of their school only, forgotten. His outstanding contribution to the medical sciences was based on the contagious character of puerperal septicemia, and was strongly opposed by his contemporaries.

At present the display in the exhibit cases gives one a glimpse of the history of vaccination, shows sketches of Edward Jenner's home and workshop and an *Early American Publication on Vaccination.* A note states that the first authentic account of smallpox and measles was given by one Rhazes, a Persian physician, and that the "Circassians used inoculation from before the beginning of the 18th century as a protection of the beauty of young girls to be sold as slaves." It is also interesting to learn that "Dr. Zabdiel Boylston of Boston made the *first inoculation in America* in 1721, beginning with his son and Negro slaves."

(Notes on other exhibits will be given from time to time.) L. M.

A DIAGNOSTIC PROBLEM

(Continued from page 195)

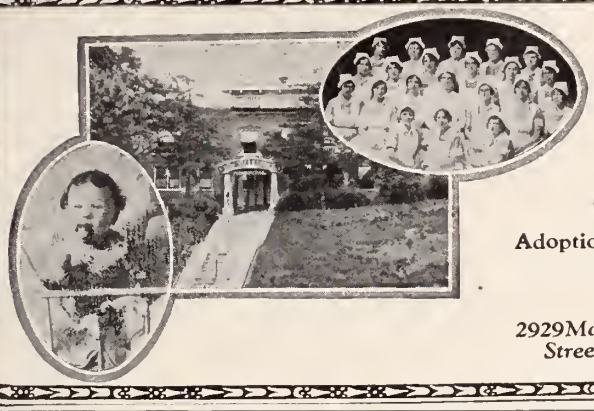
DISCUSSION

A case like this seen in a home away from the modern hospital and without any laboratory data, not even a blood smear, presents considerable difficulty often in diagnosis. Frequently one is called upon in such a case to give an opinion and a diagnosis with no further data than was obtained in the history and physical examination above.

As the case was viewed there seemed to be three possibilities; subacute bacterial endocarditis, myelogenous leukemia or pernicious anemia. The first diagnosis did not seem altogether possible because in spite of the fever, the sweating, and the "café au lait" appearance of the skin, the spleen was unusually large and not tender, and the heart murmur was not at the aortic valve and the murmur itself although harsh seemed more functional than organic. Further, there were no petechiae, and it seemed that were he suffering from endocarditis his general condition should have been worse than it was. Myelogenous leukemia was considered but it seemed that the spleen was not quite as large as it should have been, the liver was not palpable and the jaundice was rather unusual in this condition, although one could not without further study rule out myelogenous leukemia. Pernicious anemia had some points in its favor, although the age of the man was just on the lower edge of the pernicious anemia age limit. The marked pallor, the jaundice, the hard not tender spleen and the suspicious smoothing of the edges of the tongue were all in favor of this disease. The slight fever that he had had apparently was not a point against this diagnosis as we so frequently see slight fever in pernicious anemia.

With this line of reasoning a tentative diagnosis of pernicious anemia was made, although it had been thought that his condition might be tuberculosis of the lungs. Physical examination seemed definitely to rule that out. His cough probably was an acute respiratory infection prevailing at the time in the neighborhood. In order to settle the matter a blood smear was taken and examined. The smear showed the typical picture of pernicious anemia so that the diagnosis was absolutely settled.

This is one of those rather interesting cases where a blood smear becomes of such importance in a diagnosis as well as in the prognosis. The correct diagnosis in this case, of course, means life or death to this patient. With our present knowledge of



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pernicious anemia the chances are that he will recover and be able to carry on his work for, we do not know, how many years. Had he been treated for jaundice without there being any other diagnosis or had the diagnosis been endocarditis, or leukemia his condition would undoubtedly have progressed.

It is very helpful to have the assistance of the modern diagnostic methods found in a large hospital but often these are not obtainable. This case illustrates the tremendous importance of the examination of a blood smear which is a method simple in its procedure and one which requires no elaborate apparatus.

PRESS SERVICE

(Continued from page 213)

the amount of rest he takes, the quantity and kind of food he eats, should all receive special attention. And he should have a frequent medical examination.

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(Continued from page 212)

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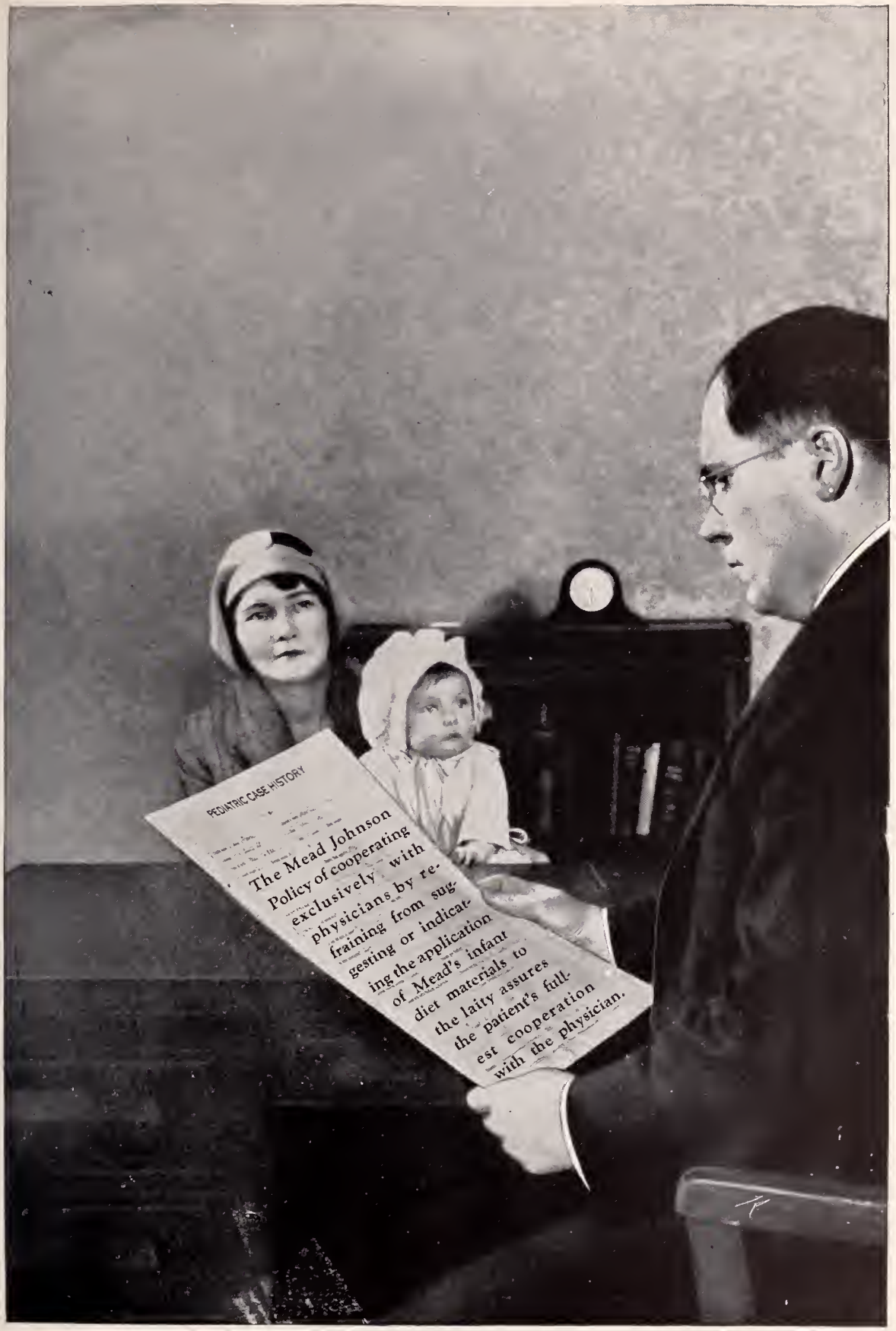
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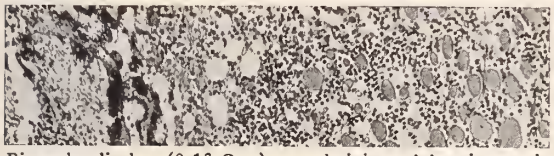

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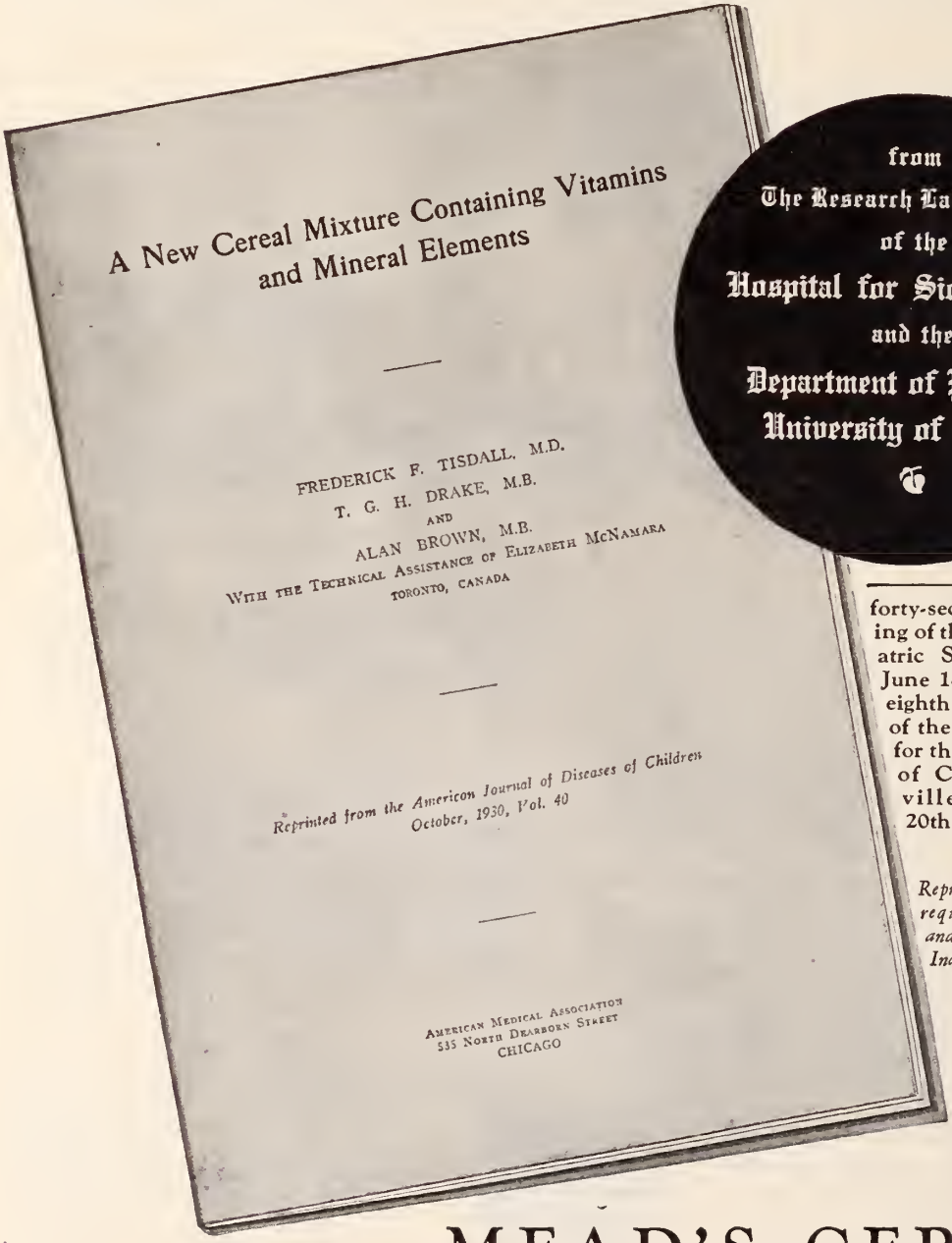
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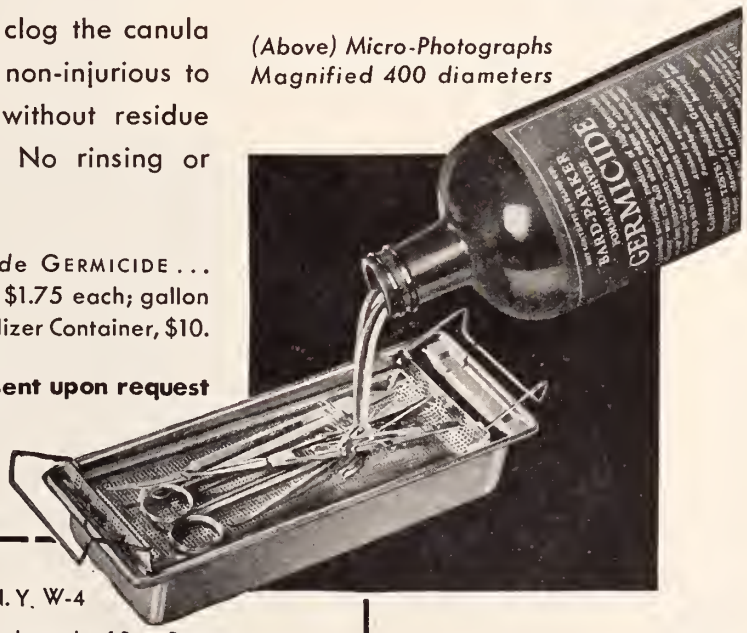

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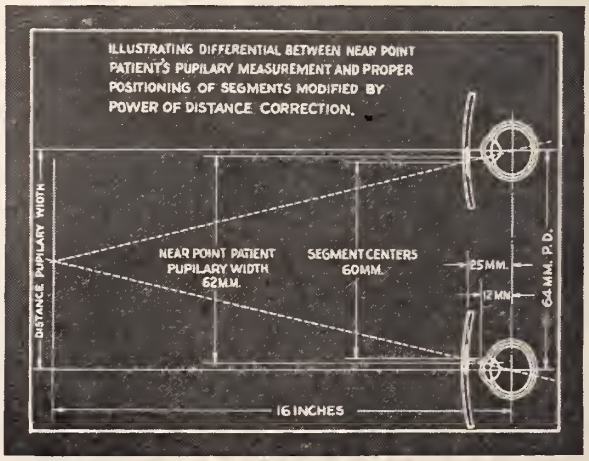

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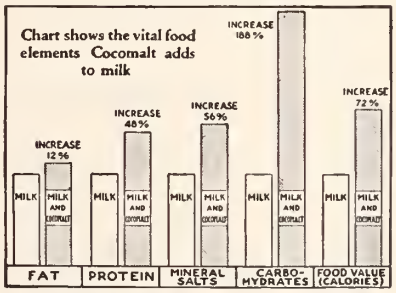

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The Wisconsin Medical Journal

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Subacute Bacterial Endocarditis*

By OTHO A. FIEDLER, M. D., and F. EIGENBERGER, M. D.
Sheboygan Clinic, Sheboygan

This paper is presented before the Society at the invitation of the Program Committee, not with the idea of submitting any new findings resulting from research work on the subject of subacute bacterial endocarditis, but rather with the purpose of again calling to mind the incidence and the essential features of the pathology and symptomatology of the disease, so that it may be more readily recognized and diagnosed.

Nineteen cases of the disease in our practice in the last few years led us to review the literature and to analyze statistics with the result that we believe that the disease is either rather more prevalent in Sheboygan than elsewhere, or that it is going unrecognized in some communities. Kinsella states that the average two-hundred-bed hospitals will encounter four or five cases a year. Hospital statistics do not show this number.

The disease was described almost fifty years ago in France. In America, Osler made a very thorough study of the disease in the early eighties and in his Gulsonian lecture of 1885, laid down the criteria for the diagnosis. Billings, in 1903, and Libman, in 1910, added materially to the subject. In 1896 Schottmueller isolated a green growing streptococcus which he described in 1910 as the specific micro-organism in endocarditis lenta or subacute bacterial endocarditis.

While in Prague, one of us reviewed the post mortem records of Dr. Ghon, for the past ten years at the Pathological Anatomical Institute. The following facts were established: Among 11,418 post mortem examinations, subacute bacterial endocarditis was found in 148 (1.3% of all hospital deaths). One hundred were male (68%), against 48 females (32%). The youngest case was fifteen years of age and the oldest sixty-seven years of age, the average age being thirty-three years. The disease was most frequently found in the third decade of life (54%). The endocardial changes appeared in great variety, usually terminating in more or less marked thrombotic ulcerous deformation of the valves. In 118 cases (80%), the endocarditis was of a recurrent type, that is, attacking valves with signs of healed inflammation. Seven cases of the known recurrent forms showed congenital anomalies in the tricuspid valve, and one in the pulmonary valve. One case had a syphilitic mesaoritis. The aortic leaflet of the mitral valve seems most frequently affected (83% of all cases), very often combined with parallel infection of the aortic valves. In 78% of all cases, these *valves* were affected by the inflammation, the parietal endocardium in 8%, the tricuspid valve in 7%, and the pulmonary valve in 0.8%.

The heart muscle showed, in all histologically examined cases, a diffuse interstitial myocarditis. The liver showed, in all cases, interstitial hepatitis. Seventy-five per cent of all cases had an embolic focal glomerular nephritis, as described by Loehlein and Vollhardt.

Embolic phenomena are typical post mortem findings in these cases. The spleen showed infarcts in 100% of all cases, the kidneys in 68%, the brain in 65%, and the lungs in 46%. Mycotic aneurisms appeared in almost 40%, most frequently in the arteries of the brain.

General anemia and fatty infiltration of the parenchymatous organs were usually found. The spleen showed, aside from the mentioned infarcts, chronic hyperplastic changes typical of chronic septicemia.

The bacteriological examination of the heart valves showed, in two cases, pseudo-

* Presented before 89th Anniversary Meeting, State Medical Society of Wisconsin, Milwaukee, Sept., 1930.

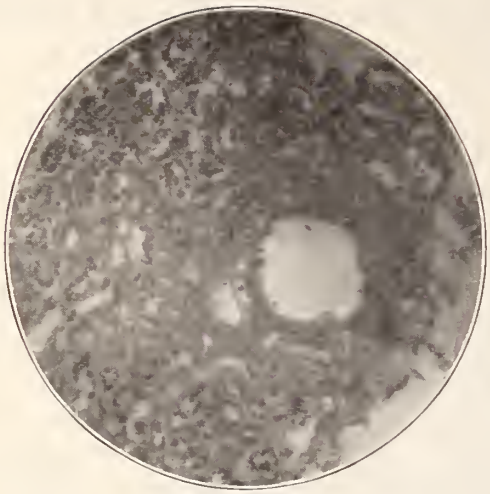

Fig. I. Section through kidney. Insular focal nephritis with periglomerulitis.

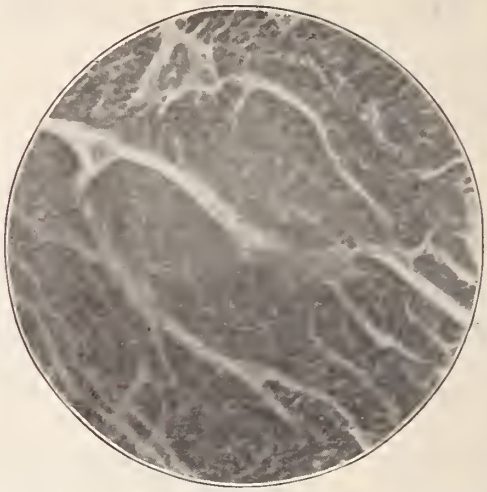

Fig. II. Section through heart muscle showing interstitial myocarditis.

diphtheria bacillus; in one case influenza bacillus; in six cases pneumococci; in one case micrococcus catarihalis; in twenty-six cases slight hemolytic streptococci, while the rest, as far as the cultures were not contaminated, showed anhemolytic streptococci of the type of Shottmueller's streptococcus viridans.

For the pathogenesis of this disease, as for all other infectious diseases, two complex factors are important: the exogenous causative agent, and the endogenous conditions of reaction.

We know now that during many of the common infections of the respiratory tract or of the joints, the local infecting organisms are occasionally found in the blood stream. Especially tonsillitis seems quite frequently accompanied by temporary bacteremia. The Prague post mortem material showed, in most of the cases of endocarditis lenta, chronic lacunary tonsillitis. Turner of Boston showed by his statistics a relatively low incidence of the disease in patients who had had a complete tonsillectomy performed.

The fact that very often the clinical beginning of the disease is marked by tonsillitis, grippe-like or other mild infection, suggests that a temporary bacteremia during such a limited local infection is the first step in the development of the fatal disease.

It may be in individuals who have just at that time a favorable focus of entrance, due to local inflammation or some predisposing local tissue conditions, that the lower bactericidal power of the tissues and the blood stream favor the bacteremia.

In 80% of all the mentioned cases the bacterial endocarditis was of a recurrent nature. Clinically there is very frequently a rheumatic heart history obtainable. The infection of the heart valves, during a temporary bacteremia, seems to be based on a local tissue predisposition.

In 1852 Luschka described blood vessels in the heart valves which were, by later investigators, attributed to inflammatory vascularization. In 1878 Koester published an embolic theory of valvular endocarditis and Rosenow, in 1912, came to this same conclusion, based on animal experimentation. Kugel and Gross of New York have rather recently proven the existence of valve vessels in a small number of normal hearts, continuing from the fetal period of life and not of inflammatory origin. Most frequently these vessels are found in the aortic leaflet of the mitral valves.

RHEUMATIC HISTORIES

Assuming the embolic origin of bacterial endocarditis, we can understand why so many cases have a rheumatic history: rheumatic endocarditis caused by subendocardial granulomas (Ashoff bodies) leads to vascularization in the healing stage,

affording a local predisposition for septic valvular thrombosis, and the fewer cases of apparently primary bacterial endocarditis may have had heart valves which were predisposed by the developmental vascularization. In support of this view the aortic leaflet of the mitral valve is attacked most frequently.

The bacterial thrombosis in the blood vessels of the valves, due to an accidental bacteremia, would mark the starting point of the fatal disease.

The valves are attacked from within. Necrosis, exudation, and reparatory processes soon produce a penetrating lesion, which brings the micro-organisms to the surface of the valve and from there into the blood stream. The frequent focal infections of the kidney and the interstitial myocarditis, hepatitis, and splenitis, are of a bacterial embolic nature. The endotheliotoxic effect of the poison causes a higher vulnerability of the capillaries leading to petechia, though some authors claim bacterial embolisms as the cause of these. The hematopoietic system is affected and secondary anemia develops.

Bacterial embolisms in terminal blood vessels seem to cause the Osler nodules, or start their destructive work on the intima of the arteries, terminating in mycotic aneurism. As the valvular process progresses, thrombotic coagula of blood and bacteria are thrown occasionally into the blood stream and lead to the above mentioned infarcts.

While the blood, at least in the beginning, would be able to successfully combat the septicemia, there is no limit to the valvular process as the source of infection. Toward the end of the disease, the bactericidal power of the blood, while high in the beginning, drops to almost zero.

Blummer states that the clinical manifestations fall into two periods; an early period with symptoms and signs of a low grade of infection, and a later period of manifestations of embolism. The onset then is insidious, usually in patients who have either a congenital lesion or a damaged heart valve. From the pathogenesis, it follows some new infection such as influenza, focal

Fig. III. Section through bicuspid valve showing characteristic thromboendocarditis. Note thrombotic vessels in the valve.

infection through the teeth, or tonsils, from which the patient never makes complete recovery, presenting low fever, malaise, fatigue, pallor, and anorexia. These gradually aggravated symptoms, or the occurrence now of embolic phenomena, finally bring the patient to his physician, who finds, in addition to the above stated symptoms, fever of low degree, rather rapid, feeble heart, possibly signs of embolism of the kidney with accompanying urinary findings, a pulmonary infarct with respiratory findings, or spleen infarct with pain in the lower left chest. Tentative diagnosis at this time may be a nephritis, tuberculosis, or, in the presence of spleen tumors, typhoid fever, especially the latter if petechia appear on the chest or abdomen, simulating rose spots.

SYMPTOMS

Often first symptoms are only shortness of breath due to anemia, and heart weakness. Again, gastro-intestinal symptoms may dominate the field with achlorhydria, dyspepsia, or loss of appetite. There is no regular sequence in the development of symptoms, but ultimately the fever, continuous or recurring, the palpable spleen, the petechia, the anemia, at times chills and with all a great weakness and fatigue occasions suspicions of a bacteremia, and a blood culture confirms the diagnosis. Osler notes painful nodes along the shins or on the finger

tips. We did not see this frequently, only in about 25% of our cases. Symptoms referable to the nervous system are common. Restlessness and apprehension may lead to a diagnosis of hysteria.

Headache is common, often accompanied by vertigo. Sleep is disturbed. Later, delirium or coma may terminate the scene. Ullom reports a case which shows typical symptoms of meningitis and we had one case showing symptoms of cerebritis.

Nutrition is little impaired for weeks or even months, though later there is loss of weight, but never emaciation.

The skin may present a peculiar brownish color which Libman designates "cafe au lait" tint. We had one case presenting a lemon tinted skin, simulating pernicious anemia.

The febrile reaction is variable. In some cases there is continuous fever without chills, others show remittance to a low level, or the fever may be intermittent with perhaps a day or two or three of afebrile state. Some patients present chills and fever, many fever and sweats, and some chills, fever, and sweats. The pulse rate is rapid, but we observed no patients who presented either febrillation or arhythmia, though others have reported such findings.

The blood picture is that of a progressive secondary anemia—hemoglobin lowered, red blood count as low as two million. In our series there was either a normal leucocyte count, or slight variations from this, either above or below normal. At times these patients may present leucopenia, and at other times a leucocytosis as high as twenty thousand. Practically always a large mononucleosis.

Early in the disease the urine may be normal, but usually shows a trace of albumin. Later, in every case, there is evidence of focal infection of the kidney with albumin, red blood cells, and casts in the urine. Albumin is never large in amount and there is usually not sufficient blood to give a smoky urine, nor are the casts profuse, but of several varieties. Blood cultures, in all cases, were positive. We made no diagnosis of subacute bacterial endocarditis on cases in which these cultures were negative. Streptococcus viridans was the most common causative agent. Hemolytic streptococcus and pneumococcus were found, but the findings from the Prague cases prove that other bacteria such as micrococcus catarrhalis, and pseudo-diphtheria may be responsible.

It will be seen that the symptoms are protean and that an error in diagnosis may easily be made, but if we accept Osler's criteria of fever, embolic phenomena, positive blood culture, in a patient who has previous heart lesion, we are not likely to make a mistake.

CLASSIFICATIONS

Libman classifies his cases into five groups:

Type 1. The usual type, quite severe, with no recoveries.

Type 2. Those in the bacteria free stage, usually afebrile, terminating fatally.

Type 3. Transitional cases, divided into three classes.

A. Subsiding bacteremia and fever, disappearing. Some recover.

B. Bacteria free, subsiding fever. These may recover.

C. Those with no fever and no bacteremia, having signs only of previous existing infection, in which an autopsy shows evidence of healed lesions.

Type 4. Those having bacteremia, positive cultures, and no fever. Symptoms rather of anemia, neurasthenia, tuberculosis or ulcer. These are the cases which Oille, Graham, Detweiler, and Salus have described. Blummer does not think that these are true cases of endocarditis.

Type 5. Apparently recovered cases, which usually have recurrence and in whom the outcome is fatal.

After all, cases described by Libman do not differ from the type here presented, except in the severity of symptoms or the outcome, and in any other disease such as typhoid fever, or acute rheumatic endocarditis, various classes on the same basis could be differentiated.

Prognosis is always bad. A few cases recover, we do not know why. Treatment in our hands had been without any avail. Anti-

septics by mouth or injected into the blood stream do not help. Vaccines, serums, immunogens, and blood transfusions were to no purpose. Surgery, as practiced by Bier in Berlin, gave us negative results. The disease runs its course ending in death, or very exceptionally, possibly in 1% of cases, in recovery, despite anything we can do.

The diagnosis is always difficult. As Osler states, "The protean character of the malady, reticence of the cardiac symptoms, and the close simulation to the other diseases, combine to render the diagnosis of subacute bacterial endocarditis particularly difficult."

If, however, patients presenting themselves with an old heart lesion, history of recent infection, and low fever, were given the benefit of repeated blood cultures, we believe that many cases more would be added to the list of those reported, and that our mortality statistics would show an increased number of these cases.

TABLE I

PRAGUE MATERIAL

Years	Total Post Mortems	Sub. Bact. Endo-carditis	Male	Female
1920	1,034	9	8	1
1921	1,032	16	14	2
1922	1,029	18	13	5
1923	964	15	10	5
1924	1,104	14	10	4
1925	1,075	12	10	2
1926	1,139	11	4	7
1927	1,085	19	10	9
1928	1,172	9	6	3
1929	1,236	15	9	6
1930	548	10	6	4
	11,418	148 (1.3%)	106 (68%)	48

Age	1-10	10-20	20-30	30-40
Cases	0	12	54	45
Per cent		8.2	37	31

Age	40-50	50-60	60-70	70-80
Cases	24	9	2	0
Per cent	16.3	6.2	1.3	

TABLE II

PRAGUE MATERIAL

Total Cases of Aortic Localization	**115**
Aorta only	16
Aorta plus mitral	92
Aorta plus tricuspid	2
Aorta plus parietal endocarditis	5
Total Cases of Mitral Localization	**124**
Mitral only	18
Mitral plus aorta	92
Mitral plus tricuspid	6
Mitral plus pulmonary	1
Mitral plus parietal endocarditis	7
Frequency of Infarcts:	
Spleen	100%
Kidney	68%
(Besides 75% show focal glomerular nephritis.)	
Brain	65%
Lungs	46%

TABLE III

THE SHEBOYGAN CLINIC

Essential Symptomatology

Heart Lesion	19
Fever	19
Embolic phenomena	19
Bacteremia and culture	19
Anemia	19
Osler nodes	5
Petechia	8
Enlarged spleen	19
Leucocytosis	6
Leucopenia	4
Normal limits	9
Kidney involved (to some extent)	
Albumin, R. B. C.	19
Spleen infarcts or embolisms	5
Enlarged liver	5
Pulmonary embolism	3
Cerebral embolism	2
Cerebral symptoms, terminal	8

TABLE IV

THE SHEBOYGAN CLINIC

Physical Findings

Emaciation		1
Gross anemia		10
Palpable spleen		19
Clubbed fingers		1
Petechial hemorrhage		11
Cardiac Lesions:		
Aortic insufficiency		8
Aortic stenosis		1
Mitral insufficiency		12
Mitral stenosis		6

Embolic Phenomena

Petechial Hemorrhages		11
Skin	9	
Conjunctivae	2	
Retinae	1	
Osler's nodes	5	
Kidney	3	
Cerebral		3
Pulmonary		1
Splenic infarcts		5
Renal infarcts		1

Cardiac Function

Complete compensation	17
Subacute decompensation	2

TABLE V

THE SHEBOYGAN CLINIC

Initial Symptoms

Asthenia	8
Headache	4
Fever	10
Sweats	1
Chills	8
Abdominal pain	1
Malaise	10
Neuritis	1
Dizziness	1
Anorexia	3
Insomnia	2
Arthritis	2
Epigastric distress	4

Symptomatology

Arthritis	4
Osler nodes	5
Dyspnoea	14
Asthenia	19
Anorexia	10
Loss of weight	4
Chills	6
Sweats	6
Cough	2
Abdominal pain	4
Dizziness	2
Headache	3
Blurred Vision	2
Aphonia	1
Syncope	2
Drowsiness	1
Insomnia	2

TABLE VI

THE SHEBOYGAN CLINIC

Age

1-10	1	
10-20	3	
20-30	5	11 from 20-40
30-40	6	
40-50	2	
50-60	1	
60 plus	1	

Bacteriology

Streptococcus viridans	15
Hemolytic streptococcus	3
Pneumococcus	1

Sex and Race

All White:	
Female	9
Male	10

Previous Infections

Acute rheumatic fever	12
Tonsillitis	3
Oral sepsis	1
Scarlet fever	1
Influenza	2
Known previous cardiac lesion	19

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DISCUSSION

Dr. W. D. Stovall (Madison): I have listened to this paper with a great deal of interest. The results of both the differential blood counts and blood cultures have particularly interested me.

They have obtained positive blood cultures in all cases. This is often not accomplished very largely I believe because repeated cultures are not made, and because incubation periods are not prolonged over a period of six to ten days.

The blood counts are also interesting. They show a leukocytosis for some of their cases and a leukopenia for others. In most cases, however, there is an increase in the number of mononuclear leukocytes. I wonder if this increase in large mononuclear cells is not the thing we see spoken of as a shift of the formula to the left, and if the large mononuclear increase is not really due to the appearance in the peripheral circulation of young forms of the granulocytes. I bring this up because there has been recently much talk of blood pictures and formulae with the suggestion that the Schilling method of counting offers differential diagnostic value in various infectious processes. This I do not credit but it does have in certain cases prognostic value. The question is, whether this value is any more serviceable than that secured by simpler methods of observation.

Dr. Fiedler (closing the discussion): I think Dr. Eigenberger, who made the cultures in the laboratory and did the pathologic work, is better able to reply to Dr. Stovall. The Journal, some months ago, published our first paper regarding bacterial endocarditis. In it we reported the fact that we had prepared and used a human serum in the treatment of the disease. This paper also gave our method of culturing.

Dr. Eigenberger (closing the discussion): It is a fact that the streptococcus viridans takes a great deal longer to grow than the other micro-organisms. If we waited thirty-six hours, the small colonies were usually distinct. In some cases we obtained them repeatedly with frequent culturing, and we practically always took the blood at the onset of fever or shortly after the temperature was high. Cultures were repeatedly negative in other cases, even when the temperature was high.

The hematologists in Prague expressed the opinion that there was no large mononucleosis but that all the mononucleated cells belonged to the myelogenous group instead of to the endothelial group.

Medical Histories and History Writing; With Special Reference to Tuberculosis

By DAVID A. STEWART, M. D., LL.D.
Medical Superintendent, Manitoba Sanatorium
Canada

A medical history has many and great values. More than any other element, usually, it helps to a proper understanding of the case, is the best basis for both diagnosis and treatment, and so to the physician, at the time of writing, is indispensable.

Besides, a history is a permanent record to be read and re-read again and again, the patient's vade mecum throughout his treatment, and a contribution he makes to the sum of medical knowledge when he leaves the hospital.

Histories are also material for research. Their study and analysis builds up medical science. In one thousand adequate histories or even fewer lie latent the possibilities of new masterpieces of medicine.

And no better training for medical students has been devised than thorough-going history taking and history writing. Reading maketh a full man, it is true, and conference a ready man, but writing makes an exact man. The pen is mightier than the stethoscope.

The whole investigation of the patient's condition is like that of a court trial, with the diagnosis as the verdict after all evidence has been heard. The writer of a history is collecting evidence and examining a witness. He may constitute himself for that purpose pretty much a whole court of law —judge, lawyer, detective, clerk, and all the rest. He is not merely to take what is given him, but to hunt for what he needs, follow up every clue, sift the essential story out of a mass of fiction and irrelevant fact.

The patient, it must be remembered, has not had the training of a physician, and may be vague or wrong in his answers without intending to mislead. He may deny cough, yet on close questioning admit a fairly frequent "hack," or a cough every morning on rising; will say he does not expectorate, but will admit that he clears his throat frequently, especially in the morning. He will explain that everybody does these things. On the other hand he may be sure he has had night sweats, whereas he has just occasionally had one blanket too many.

Separate rigidly between fact and the patient's fanciful explanation of fact, or even your own. Distinguish clearly between what he did have, what he says he had, and what he says Dr. X. said he had in that obscure illness twenty years ago. What patients say doctors said would make even Hippocrates turn over in his grave. Mix judgment with the record. A history is not a stenographic report. A good history cannot be picked up on the surface,—it must be dug for. You must use material the patient has given you, but it is your history, your product, your finished structure, and not his.

Let the history be just as long as is needed to be complete. A short history is best if all the facts are suitably stated. Get all the significant data. Ask all relevant questions. Then edit your material. Sift and summarize before final writing. A disorderly jumble of all the patient may have said is fit only for the waste basket. Do not pad. Histories are not judged by weight, length or surface.

Some order in the presentation of a history is essential, a logical sequence in the development of the enquiry. Such an order may be suggested in such a pamphlet as this, but it should soon be transferred to the cerebrum and carried there. History sheets should be of plain paper. Printed forms with blank spaces to fill in perfunctorily are an abomination for physicians, and for students an abomination of desolation. No suggested or habitual order should be followed slavishly. All stories do not flow naturally in the same channel. Even a medical history should sometimes be made dramatic.

About some important matters, it is not enough that they be mentioned only when present; their absences should be noted. Histories to be of use in statistical study

must record negatives as carefully as positives.

No idea can be more wrong than that the writing of histories is drudgery beneath the dignity of a full-fledged physician. A good physician differs from a poor one chiefly in this, that the former writes histories while the latter does not. A diagnosis has often been missed by an experienced physician who does not write, and made easily by a man of much less experience who does write. A student can consider each opportunity to write a history a golden opportunity to advance his study of the science and the art of medicine.

A history, then, is worth doing, and so is worth doing well. Being of value, and of permanence also, it should be, according to the rules of the art, in good form and style, accurate, well arranged, easy to refer to, neatly put down, well written. When it is finished the writer—or should we not say, the author?—should sign it, showing thus a proper pride in his product, and assuming responsibility also.

However well a history has been written, it should usually be presented by being spoken and not by being read. Your audience cannot be expected to carry away in their memories what you, the historian, cannot carry to them in yours. And they can remember best what is given to them *as you remember it*, that is as it comes to you when you present it,—well and skillfully of course, —in ordinary speech.

HISTORIES IN TUBERCULOSIS

The tuberculosis history must be a full one. If a man has a broken leg, or a child scarlet fever, the history elements are few and easy to get. But the beginnings of tuberculosis are involved in almost all a man has ever been and done; in his parentage, associates, housing, work, play, habits, wages, temperament, nationality, social conditions and travels to and fro. It is a part of all that he has met.

A generation ago family history was considered important because definite hereditary transmission of tuberculosis was believed in. It is important now, though hereditary transmission is not believed in, because family contacts are the earliest and most constant, and also, perhaps, because of inherited predispositions.

There is no more important part of the history than the record of previous illnesses. Acute respiratory diseases of all sorts, "cold," "grippe," "flu," are easily confused with tuberculosis, or may very definitely open the door for it. A debilitating disease such as typhoid fever doubles the chance of tuberculosis breakdown in the next five years. Digestive disturbances and nervous conditions may be confused with, or symptoms of, or may definitely lead to, tuberculosis breakdown. Pulmonary diseases of all sorts—pneumonias, pleurisies, asthmas, spells of hoarseness, all must be canvassed and recorded.

In most diseases the time of infection and the time of onset of symptoms are separated by a brief and fairly constant interval; but in tuberculosis the interval may be a few days or two score years. This interval, long or short, must be reconstructed, filled in, charted, the events pieced together by careful enquiry, and the course of the disease thus traced. It is remarkable, once the diagnosis is made, how many old illnesses and debilities can be strung on the tuberculosis string.

General conditions, social, industrial, community and personal, have already been mentioned. A most important enquiry, even with diagnosis in view, is that with regard to work, amusement, recreation, rest, income and output of energy and conservation or dissipation of strength. One of the chief causes of health breakdown is the overspending of energy, more usual in so-called play than in work and in unnecessary than in necessary effort, and more usual after six o'clock than before it. Many so-called recreations do not recreate, do not restore the balance after labor, but rather dissipate energy, until natural fatigue after labor becomes unnatural exhaustion after play. The social pace a woman sets herself, the amount of her nonessential activities, is a much more important element in her history than the amount of proper housework, or the disease her grandmother died of.

THE TUBERCULOSIS SUSPECT

Whenever written, even if some time later than admission, the first history should tell conditions as at admission to the sanatorium or hospital.

Date all principal events exactly, using calendar dates, and writing names, not numbers, of the months. Say "On June 14, 1921" rather than "at twenty" or "four years ago" —and never "14/6/21." Be chronological. In a military history be especially exact in dates and data.

At the top of the first page write the name, age and address of the patient, date of admission and of the writing of the history. Use one side of the sheet, and leave margins.

Use, if you wish, recognized abbreviations such as aet. (aetas), F., M., B., S. (father, mother, brothers, sisters), a. & w. (alive and well), d. (died), etc.

Though there are summary sheets to be used in addition the history should be complete in itself. It should not, however, cover physical examination.

Your first copy will rarely be good enough. Almost always rewrite when you have all your data assembled; still better, type; then sign the completed history.

The following is simply a bare outline, to be added to at one point or another in every case.

Complaints on Admission:

Brief enumeration of what the patient himself volunteers about abnormal conditions, his reasons for seeking treatment.

Family History:

Question about *parents, brothers, sisters, children* and *consort*. State whether living or dead; if dead, cause of death; if living, general condition of health. Give outline history, with dates, of any significant diseases they have had, and relation of patient to them, with fuller details of pulmonary disease, or any form of tuberculosis.

Grandparents, uncles, aunts, cousins, contacts or *associates*. Enquiry need not be so minute, but should cover tuberculosis and other pulmonary diseases, including bronchitis, heart disease, asthma, neoplasm and glands.

Personal History:

The general course and main incidents of the patient's life, except illnesses, which will be given elsewhere, also race, should be enquired into.

Childhood: Place in family—first, second or third child, etc.; breast fed or not; birthplace; general conditions under which childhood was spent, town or country, housing, school, associations in childhood with sick people especially tuberculous, etc.

Occupations: A fairly full record of former occupations with their general conditions; present occupation in greater detail as to hours, dust, laboriousness, worry, ventilation, habits of comrades, etc.

Habits, Recreations, Etc.: Very often the hours off work and how they are spent have most to do with the breaking down of resistance. Report on spare time or evening employments, games and recreations, dissipations of energy, also on alcohol and tobacco. Enquire closely into hours of work, recreations, rest and sleep, and put down exact record.

Housing: If significant, give some particulars of past residences; but more detailed as to present house, ventilation, number of rooms, windows especially in bedroom, open or closed, general conditions.

Military History: This is a section of personal history. Put down with accurate dates enlistments, periods of service, tranfers to England, to France, from France, from England, discharge. Record barracks, camp and service conditions if relevant; wounds, anaesthetics, illnesses, leaves; pension, etc. This account will serve as a basis for official reports, so should be carefully compiled.

Marriage: Date, age, change of occupation, etc.

History of Maternity:

Dates of childbirths and miscarriages; difficulties, recovery from pregnancies, the puerperium, lactation, child care, etc.; relation of maternity to general health and to present illness.

Previous Health Conditions and Illnesses:

Childhood Diseases: General health in childhood; diphtheria; scarlet fever; pertussis; chicken pox; mumps. Indicate negatives as well as positives, thus—"has had diphtheria, pertussis—has not had chicken pox, mumps."

Other Diseases: (Record negatives as well as positives.) Adenitis; typhoid; sepsis, rheumatic attacks or pains; malaria; lues; gonorrhea; influenza; surgical operations; anaesthetics, trauma, etc.

Review of Systems:

Respiratory: Nose or mouth breather; specially subject to "colds." History of dyspnoea, hoarseness, cough, expectoration, blood, chest pain; of pneumonia, pleurisy, influenza, "colds," "asthma," "catarrh."

Circulatory: History of palpitation, oedema, dyspnoea, pain in precordium.

Gastro-Intestinal: Appetite, diet preferences, fats (meat, butter); indigestion, pain or discomfort; relation of food to these, location; "sour stomach," gas nausea, vomiting; bowels, constipation or diarrhoea. Hemorrhoids.

Genito-Urinary: Pain, frequency, changes in urine.

Men—scars, discharges, phimosis.

Women—menses, when they began, regularity, type, duration, amount, pain, discharge.

Nervous: Sleep, soundness, how long; loss of consciousness, convulsions; chorea, headache, character, duration, etc.; tremors, gait; temperament, irritability, etc.

Eyes:

Ears:

Nose and Throat: Tonsillitis (operations, etc.).

Present Illness:

Go back as far as you can, remembering that the duration has an important bearing on prognosis. Disease is insidious and patients usually appreciate only gross symptoms. Enquire for earliest symptoms and record in detail as they develop—cough (character, time); expectoration (character, amount, time); pleurisy; dyspnoea (at night, on lying down, on exertion); hemoptyses (dates, amounts); loss of weight, of appetite, of strength, malaise; fever; sweats at night, on exertion, in hot weather; hoarseness; pain in throat. Other symptoms.

Treatment to Date:

Previous examinations, diagnosis, treatment, drugs, if any. Routine of life before admission and after diagnosis, especially amount of rest taken.

SUMMARY

Even after this outline, or any other outline, has been followed, and these or any other suggested questions answered, the history is not finished, though much of the material for it should now be ready to hand.

Go over it all again with the patient, correct, amplify, make more definite, supply missing dates and data, follow new clues, make consecutive, and get the story as a whole better arranged in your own mind. Then, recast and rewrite in such manner and form that you will not be ashamed to sign it.

Undulant Fever*

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Nicolle, the Nobel Prize winner in Medicine in 1928, in speaking of undulant fever, stated his belief that it is the infective disease of the future. At any rate, its epidemiological features hold the center of interest in public health work in North America today. As "Malta fever" it has been known on the islands and along the shores of the Mediterranean Sea since antiquity, even Hippocrates describing protracted fevers lasting for months, with recurring pyrexial waves that may indicate the first description of the disease, though the haze of antiquity somewhat obscures its accuracy. In 1859 Marston gave the first full and minute description which made identification possible and established it as a clinical entity.

In 1887, David Bruce, then a British army medical officer, fortunately, in a belligerent mood, challenged a certain colonel to a fist fight, with the result that he was court-martialed and sent to the tropics of the Eastern Hemisphere. As he and his young wife reached Malta the problem of Malta fever engaged his attention, and with the thousand dollars he had in his possession he purchased a number of monkeys, and through his experimental research definitely established what he called the "micrococcus melitensis" as the specific cause of the disease. As a reward for his original work it is stated that he was asked to return to the British Isles to engage in teaching Medicine, and his epigrammatic answer, "Those who can, do, and those who cannot, teach," has become a matter of history. That David Bruce's work in Malta was not merely a flash in the pan is proved by the fact that he subsequently went to Africa and established the tsetse fly as the intermediary host in the transmission of African sleeping sickness to man. The name of David Bruce should be emphasized as of superlative historical interest.

In 1897 Bang, in Denmark, isolated the Bacillus abortus as the etiological factor in contagious abortion in cattle, but it was not thought at that time to be pathogenic for man. In the same year, Wright and Semple showed that the diagnosis of Malta fever

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could be made with the agglutination test. From 1904 to 1907 the British government investigated this Mediterranean scourge under the direction of Bruce, and it was established that the goat and its milk supply were probably the source of infection. It was at about this time also that a herd of Maltese goats was brought to America on the steamship Joshua Nicholson, and many of the crew of the vessel developed Malta fever with the exception of a few who partook only of boiled goat's milk. When this herd was found to be infected with Malta fever, and cases appeared in this country where milk from the same herd was used, it was demonstrated beyond doubt that the goat was the source of infection in human beings. Gram, in this country, in 1914 discovered a related organism in swine.

In 1917 Alice Evans proved the intimate relationship between the micrococcus melitensis and the Bacillus abortus, and found the cultural, biochemical and morphologic characteristics to be more closely identified, than the various strains of pneumo- or meningococci. It has also been shown that the Bacillus tularense and the Bacillus bronchiepticus are very closely related, and that cross agglutination occurs at least with the former.

Meyer and Shaw, in 1920, proposed the generic term "Brucella" to designate the group of organisms which produced undulant fever in honor to Bruce.

Although Craig, in 1903, described the first case of the disease developing from the caprine strain in the United States, and Gentry and Ferenbaugh also reported the incidence of the disease among the goat herders on the Mexican border in 1911, major interest attaches itself to the discovery by Keefer in 1924 that the abortus type of infection from cattle was specifically pathogenic for the human. Soon thereafter other instances were reported by Evans, Duncan, Huddleson and Carpenter, and the latter found that the Bacillus abortus acted in full conformity with the postulates of Koch. Since then Brucella suis has also been found pathogenic to man.

As early as 1913, Larson and Sedgwick in Minnesota suggested the possibility of human infection with the abortus organism, but actual clinical support was lacking. Since that time over two thousand cases have been reported in the United States and Canada, and one might safely add, that a perusal of the facts would indicate that it is being found in direct proportion to the effort expended in its search.

Hughes, in 1892, first suggested the name "undulant fever." Considering the more restricted geographical terminology of "Malta fever" as inaccurate, Hughes' term is now generally employed and recently the British medical associations in Malta has suggested that the term "Malta fever" be discontinued and replaced by the more generally applicable name of "undulant fever," so called because of the characteristic wavelike tendencies in the pyrexial curve. How much influence the local real estate men and hotel proprietors had to do with the proposed elimination of the name is not stated, but one can well imagine the storm of protest that might arise were we to call tularemia, "California fever."

BACTERIOLOGY

It seems rather curious that for twenty years after the discovery of the Bacillus abortus by Bang its close relationship with the micrococcus melitensis was unknown. After the work of Miss Evans in establishing the approximate morphologic and cultural identity, the study of the bacteriology of the disease has been greatly facilitated. With the newer terminology as suggested by Meyer and Shaw in 1920, the caprine strain is designated as "Brucella melitensis," the bovine strain "Brucella abortus," and the porcine strain as "Brucella suis." The organisms are pleomorphic, non-motile, short and slender, frequently with rounded ends, at times coccoid, and at times bacillary in shape. They are readily stained with ordinary dyes, but are negative to Gram stain. The organisms grow with some difficulty on various media and methods of culture have been devised, particularly by Hardy and Huddleson, which aid in the differentiation of the various strains. Agglutination absorption tests, varying growths under increased carbon dioxid tension, the selective

action of dyes in media toward growth, glucose and nitrogen metabolism methods, hydrogen sulphide production, and the relative pathogenicity of the varieties to experimental animals—all aid in the identification of strains, but for these special methods the publications of the authors mentioned should be consulted. Of these the agglutination absorption test has proved of some value, particularly when a differentiation between Brucella melitensis and Brucella abortus has been in question. This test is based on the fact that if Organism "A" absorbs all agglutinin with the same titer in the serum as Organism "B" they are identical, and if not, the organism causing an agglutination in the higher dilution is identified as the agent causing the disease.

EPIDEMIOLOGY

The various strains, it is believed, may primarily have originated from one source, and have assumed cultural variations by their growth in other species. All the strains, however, seem to have pathogenic tendencies toward animal species, and the specificity of the pathogenicity seems to be interchangeable for varying species.

Since goat's milk was proved to be infective for the human, the logical corollary has been to assume infection of the human species by Brucella abortus as of bovine milk origin. However, it is now well known that direct contact is likewise a formidable factor in the dissemination of the abortus type of disease, and certainly so in the case of the porcine infections. There is still a good deal of controversy relative to the degree of infectivity of contaminated milk, because of the low incidence of the disease in the general population in spite of the widespread use of raw milk as a food. It must be remembered, however, that because of the dilution of milk as practised in the dairy industry, and the reasonable methods of care taken at the present time for the preservation of milk, that the bacterial count is of necessity rather low, and with the varying degree of individual resistance the relative low incidence in the human can be explained. Probably many instances of undulant fever of the abortus type in man are derived through direct contact with infected cattle, as in the case of farmers, veterinarians, packing house workers, etc. This is particularly true in the porcine infections, in which the milk supply plays no part, except insofar as cattle may be infected by the porcine strain and ultimately excrete the organisms in the milk. That many of the infections in the human derived from cattle are of the porcine strain has been proved and cannot be doubted. In certain states in which the swine industry is important, as in Iowa, notably, the porcine infection is as common if not more common than the bovine strain. Except for the instances derived from raw cow's milk, porcine infection must be spread by direct contact. It is possible that the prevalence of the porcine strain in the Middle West of the United States is due to infection with a mutation form in the hog because of the close contact with cattle infected with the bovine strain.

MISCELLANEOUS DATA

From the statistical reports it is evident that males are affected about three or four times as commonly as females. However, in eliminating occupational hazards which cause direct contact with infected animals, this proportion is not so apparent, and is nearly equal. It is my impression that men are more commonly drinkers of raw milk than women, and I believe that this may likewise be a factor in the apparent increased incidence in the male.

The age incidence of undulant fever varies considerably. It occurs more particularly, and strangely enough, between the ages of 16 and 45, approximating the period of sexual activity.

Dr. C. O. Kohlbry of Duluth has reported a patient of fifteen months with clinical and laboratory evidences of the disease, and the condition has occurred as late as the eighth decade of life.

The occupations most commonly affected are those who come in direct contact with infected animals, as farmers, farm employees, packing house workers, and anatomical laboratory workers. In the general population, where the infection is probably derived from the drinking of raw milk, the

professional and clerical class and students appear to be particularly susceptible.

Previous illness of any type seems to have no importance in the subsequent development of the infection. It is believed that a debilitated state tends to predispose.

Hardy has proved that 70 per cent of the cases occur in the rural districts and in cities smaller than 5,000 in population. The hazard is distinctly rural rather than urban, the latter infections occurring particularly in packing house workers, and notably in places where pasteurization is not practised on a large scale.

ONSET AND CLINICAL FEATURES

The incubation period of undulant fever has been approximately determined as from a few days to two or three weeks. The British Commission believes that the latter period is the usual one. In accidental laboratory infections, however, the incubation period has varied from seven to twelve days.

The initial symptoms of undulant fever vary widely. The disease begins insidiously, even more so than typhoid fever. The onset is characterized by a tendency to fatigue, a reduction in the appetite, a gradually increasing fever, headache, and the usual muscular soreness and discomfort associated with the acute infectious diseases. A chilly sensation is not uncommon, but is not sufficient to be called a major symptom. Instances have been reported where the onset was more abrupt and more dramatic. As a rule, however, it is difficult to establish the date of onset of the disease definitely, because of its slow phase of development. After a few days the temperature becomes more elevated, and one of the more characteristic symptoms intrudes itself, namely, profuse sweating, occuring at night. Other subsidiary febrile symptoms begin to manifest themselves, such as insomnia, headache, aching of the joints or muscle groups, and at times a slight and variable cough. Nausea and vomiting are inconspicuous. Constipation and diarrhea may be observed, but are, as a rule, unimportant concomitants of the infection. It is rather astonishing that a disease which causes at times so high a fever, and runs so protracted a course, should be unaccompanied by the extreme debility found, as a rule, in typhoid infections. Many of the patients are sufficiently strong to permit a continuance of their business, and even those who are enforced to bed rest do not exhibit the tendency to mental sluggishness rather characteristic of long standing acute illness. Many patients feel able to follow their usual activities in the morning, only to be the victims of a severe lassitude as the day goes on.

The FEVER is, at times, a very characteristic symptom, particularly in the instances running a more protracted course, but variations are common, in fact, so common that a classification based on the type of fever should not be considered as of value. The true undulant type of fever, though most striking, occurs more commonly in the more chronic cases. The temperature rises in steplike gradations, not unlike typhoid fever, for from seven to ten days, reaching a higher point each day, and revealing a morning remission to or near normal. The evening temperature may be as high as 102 to 105. After the crest of the fever has been reached there is a gradual fall by lysis for a like number of days, to an approximate normal. The cycle of fever may last from four days to two weeks, or even longer. In the true undulant type an afebrile period then follows for several days, to be followed by another wave of pyrexia, usually not so severe, and not so long in duration as the first cycle. These undulations tend to repeat themselves until the infection subsides, and as is well known, may persist for months, or even for as long as two years. At times the fever is of the septic type throughout, intermittent or remittent in character, and exhibits a rather extreme variability. In some of the clinical cases of shorter duration the fever does not persist for more than two weeks, and may not reach an elevation over 101 or 101.5.

Though chills are not uncommon, severe rigors are not characteristic, except in the more virulent cases and in those with a high degree of fever. The chill is characteristically followed by a rising temperature, and the latter by a subsequent sweat, which is extremely profuse and quite characteristic.

In some instances a noticeably offensive odor has been described. These sweats are often stated by the patient as being drenching in character, and sufficient to necessitate the repeated changing of bed linens and garments.

These general symptoms, as stated, are more or less characteristic of all severe protracted fevers, and although none of the symptoms of undulant fever is pathognomonically characteristic, there are some which are of more diagnostic importance than others. In a list of symptoms as occurring in 125 instances reported by Hardy, weakness was present in all of that number, sweating was complained of by 97, feverishness by 93, chilliness by 92, loss of weight by 89, loss of appetite by 86, and headache by 71. Actual chills occurred in but 42. Other symptoms, such as general aching, backache, abdominal pain, nausea, vomiting, sleeplessness and cough, were complained of far less commonly.

Arthralgia, or a painful condition of the joints, at times shifting in character, involving particularly the joints of the extremities, was present in 36 per cent of the series. Physical signs of arthritis, however, are usually lacking. Hydrarthrosis has been reported as being present in some instances. The arthralgic symptoms usually develop after the height of the disease has manifested itself, and though not usually present, is quite characteristic.

Abdominal pain is at times complained of, and anorexia is frequent; nausea and vomiting rather rarely. Constipation is the rule. The abdominal symptoms throughout, however, are inclined to be general, and rarely have any localizing significance sufficient to offer diagnostic difficulties in eliminating organic abdominal disease.

Except for slight soreness in the throat in a few instances and occasional instances of coughing, pulmonary symptoms in the average case are minimal. Unless orchitis or epididymitis supervenes as a complicating feature, genito-urinary symptoms are inconspicuous.

The pulse is usually increased in proportion to the fever, and is subject to labile variations because of the febrile remissions. As the condition increases in severity or in duration the pulse rate becomes accelerated.

PHYSICAL EXAMINATION

Although there is a marked variation in the general appearance of those ill with undulant fever, the great majority of the patients do not appear to be very ill. They are physically quite comfortable, mentally alert, and the sensorium unclouded. As in all febrile conditions, the tongue may be coated. The chest examination reveals no unusual cardiovascular findings, but rales and rhonchi in about 10 per cent of the cases of undulant fever indicate the presence of bronchitis or bronchopneumonic areas. In about 20 per cent of those afflicted the abdominal examination indicates an enlargement of the spleen. Tenderness, if present, is rarely localized. The liver is enlarged in 5 to 10 per cent, according to compiled clinical observation.

The lymph glands are at times enlarged, and rarely an eruption of the skin of the macular type has been observed. Veterinarians have noted the occurrence of a rash on the forearms after removing a retained placenta from aborting cattle, which to their minds suggests the probability of a local skin irritation from the infective agent.

As has been stated, swelling of the testicles occurs in about 4 or 5 per cent of all instances. The joints, though subjectively sore and tender to touch, are rarely swollen. The characteristics of the temperature curve and the pulse rate have already been stated.

The urinary examination not uncommonly shows a febrile albuminuria, but nephritis does not occur.

The blood examination indicates no marked anemia until the disease has been existent for some time, when the usual toxic type of secondary anemia may be noted, with a reduction in the hemoglobin percentage and the red blood count. The white cells are not, as a rule, increased, unless complicating features intervene, but on the contrary, a leukopenia is noted in the majority of cases, oftentimes under 6,000, and suggesting the possibility of typhoid fever or malaria. The differential count reveals a re-

duction in the percentage of polymorphonuclear neutrophils, and a corresponding increase in lymphocytes. Monocytes are said to be increased oftentimes, but from the statistics, evidently not so commonly in the abortus type as in those of caprine origin.

AGGLUTINATION TESTS

In many of the states in the union agglutination tests for undulant fever are performed on all samples of blood sent in for the Widal test. A standard technique has been described by Hardy, which permits of the rapid elimination of negative tests by a macroscopic technique and a more detailed examination of the suspicious sera by microscopic measures. Since the percentage of agglutination in the general population is about 5 per cent, the degree of dilution necessary for agglutination is of value. It is generally believed that agglutination in a dilution of 1:80 may be arbitrarily accepted as an indication for investigation of the case; concentrated dilutions rarely indicate an active infection, but rather point to a past clinical or subclinical invasion. In most instances of active disease, the titre is from 1:320 to 1:5120, and may be even higher. In the state of Minnesota agglutination tests are not made with the caprine type of organism, since the danger of laboratory infection seems to be considerably greater. Tests are only made for the abortus type and for the Bacillus tularense, which frequently reveal confusing agglutinating phenomena. This tendency for cross agglutination with the Bacillus tularense renders it advisable to make absorptive agglutination tests, so as to differentiate the cross agglutination from the true. It likewise makes it imperative that all positive Bacillus tularense agglutinations should be checked with agglutinations for undulant fever, lest the diagnosis of the latter be overlooked.

The important thing to remember about agglutination tests is the fact that if it is not supported by suggestive clinical data the diagnostic considerations of undulant fever are not met.

In about 5 to 15 per cent of the instances of undulant fever it is thought that agglutination tests are not positive. To meet this discrepancy skin tests have been advised, but up to the present time have not been performed often enough to warrant any certain conclusions. The test, however, bears much promise for the future in the further diagnosis of the disease.

In sending blood to the laboratory for the purpose of testing it is advisable to send 5 to 10 c. c., and important to mark the specimen for the purpose intended, so as to avoid confusion with the more commonly done Wassermann reactions.

BLOOD CULTURES

Blood cultures when positive are the sine qua non in the diagnosis. The technique, however, is rather involved, and the agglutination test is so much more rapid and facilitates dispatch in the diagnosis. Nevertheless, by careful technique the organism may be isolated from a high percentage of the patients whose blood agglutinates the organism in those clinically affected with the disease. A successful procedure demands a suitable medium, prolonged incubation, and in some instances special technique for its elucidation.

DURATION OF ILLNESS

In one of the cases under my observation the total duration of illness was about two to three weeks. As a rule, it extends from six weeks to six months, and in rare instances has been prolonged to a few years.

The period of onset is sometimes difficult to establish because the disease develops insidiously in most instances, and the patients are not aware of their incapacity until the disease is well advanced. Some patients are ambulatory throughout.

DIAGNOSIS

If the diagnosis of undulant fever is kept in mind, it is, as a rule, not difficult. In two patients in whom I suspected undulant fever as being present, clinically, and in whom I received persistently negative agglutination tests, tuberculosis was ultimately found to be present. On the contrary, in two instances where an agglutination was present, with a high titre, there was nothing about the patient's condition to suggest the pres-

ence of undulant fever, the test having been made as a routine measure.

Conditions most commonly confused are tuberculosis, malaria, sepsis, subchronic sinusitis, subacute bacterial endocarditis, or rarely, as in one of my cases, Hodgkin's disease. If one bears in mind, however, the following characteristic phenomena of the disease, an ultimate correct diagnosis can usually be made, namely: long standing and variable fever, with a tendency to remissions; profuse sweating; arthralgia; enlargement of the spleen; the alert mental condition and good general appearance of the patient; the leukopenia, with a tendency to monocytosis; a positive agglutination test or a positive blood culture.

TREATMENT AND PROPHYLAXIS

The treatment of undulant fever is symptomatic. Some investigators have reported favorable results through the intravenous use of certain aniline dyes, but in the hands of others, this has been unsuccessful, and is rather generally regarded as ineffective. The same is true of treatment with vaccines and sera, and the use of the former has been attempted recently, again, with varying reports. It would appear to be rather strange, however, that in a disease where so many antibodies seem to be present that a vaccine would be of any particular value. There is at least no general agreement as to results. Foreign protein therapy has been reported in the literature, but likewise with indifferent and conflicting reports.

The essential feature in cutting down the period of invalidism and delayed convalescence seems to be an insistence on rest in bed, with treatment of individual symptoms as they arise, and careful nursing.

The question of paramount importance presently is the prevention of the disease. Infection from infected goats in one way or another in the northern states is a problem of little importance. On the Mexican border, the situation is different, since caprine infection is quite prevalent. As a comparison of the likelihood of infection from this source, it may be stated as pointed out by Blumer in his article, that there are two million two hundred and fifty thousand goats, approximately, in Texas, Arizona and New Mexico, and only two thousand eight hundred and ninety-three in Wisconsin. The problem of hogs is somewhat different, since the possibility of contact infection by veterinarians, packing house workers, meat cutters and so on is considerably more likely. Hardy has pointed out that in Iowa infection through hogs is a very strong likelihood. In Iowa, according to the Year Book of Agriculture, 1927, there are ten million six hundred fifty thousand hogs, whereas in Wisconsin there are only one million eight hundred sixty-three thousand. Packing industries in Wisconsin are also more definitely circumscribed. Facts are not definitely known as to the extent of the danger from infection through actual contact with infected hogs.

Efforts at the control and the prevention of the disease in cattle and the ultimate elimination of the disease in domestic animals is going to prove extremely laborious and will probably not be productive of any tangible results for a long time. It is believed that the transportation of blooded cattle from different parts of this country has proved to be a factor in the propagation and dissemination of the disease. Formerly, when the herds were more or less isolated, the disease was not so wide-spread. If the farmer can eliminate the disease from his herd, the problem will not be so difficult in the future if all purchased animals are tested before adding them to the herd. If only a few animals in a herd are found infected, they should be removed. Since the calves are not necessarily infected, it is possible to build up a clean herd through the offspring of the infected ones by practicing prompt segregation. Every specific herd, however, must be treated as an individual problem, rendering it extremely difficult, since the problem is not only medical but also of vast economic importance.

Prophylaxis in the human, therefore, at least for the immediate future, will have to depend on a wholesome, sanitary milk supply from a herd known to be free from the disease, or through pasteurization. Undulant fever may be a problem of vast economic importance, and at the present time

it is of sufficiently great potential significance that laws requiring wholesale pasteurization may have to be enacted. The largest dairies at the present time are equipped with such pasteurization plants and are anxious to have laws passed which will enforce this treatment of the milk. Necessarily, great opposition will be met through the farmers and smaller dairymen who will find pasteurization an expensive expedient which might eliminate them from the competitive market unless co-operative pasteurization is practiced. The hope of preventive vaccination of the human or of the animal stock has not yet been realized as a satisfactory mode of prevention. People who are in frequent contact with infected animals or their carcasses should be educated in the importance of pursuing proper prophylactic measures in the handling of this source of infection.

DISCUSSION

Dr. W. D. Stovall (Madison): Dr. Hirschboeck has presented this subject with great clearness. I was delighted to hear him emphasize the fact that B. abortus organisms have no selectivity for special organs or system of organs, and no specifically acting toxin and therefore produce no highly characteristic clinical manifestations.

There is a syndrome usually associated with undulant fever which is highly suggestive. This syndrome is weakness, loss of appetite, night sweats, and fever in a patient who does not appear sick and who, after short periods of rest, feels well.

The result of agglutination tests also requires interpretation. It is always necessary to associate the result of these reactions with the clinical condition of the patient to make a proper interpretation of its diagnostic value. A positive agglutination is not in itself diagnostic. The diagnostic value is determined by the titer and the clinical condition of the patient. We report positive tests only in those cases in which the titer goes as high as 1:80 or higher. Patients whose blood serum gives a positive test in lower dilutions, 1:40 or below, may have undulant fever. The literature records cases which have passed through an attack of this disease and never given a positive agglutination reaction although blood cultures were positive for B. abortus.

We receive a large number of specimens of dried blood. With these specimens we do a microscopic agglutination test. We do not give out positive reports from such tests. If such a test is positive we ask for whole blood and with the serum do a macroscopic test.

The Surgical Treatment of Pulmonary Tuberculosis*

By J. W. GALE, M. D.
Madison

A census taken for the year of 1925 in the State of Wisconsin shows that 2,200 patients suffering from pulmonary tuberculosis received treatment in private sanatoria and in state supported institutions of hospital nature. The census taken for the year of 1929 shows that 2,600 patients received similar attention at a cost of over one-half million dollars. This ever increasing group of tuberculous cases makes the annual loss to the state, which is already heavily burdened by the support of numerous other institutions of similar nature, an appalling thing. If one realizes that the arrest of the disease in a fair percentage of these cases may be expedited and accomplished by surgical means, no member of the medical profession should hesitate to learn and utilize the indications for such treatment.

The surgical treatment of pulmonary tuberculosis is a development of the present century and one of the most important advances made during the past twenty years. During this time we have learned its applications to the treatment of the disease and the lingering idea that anything but the rest cure is contraindicated has been gradually dispelled. At the present time numerous patients with pulmonary tuberculosis are receiving the benefits of surgery. Many of these cases have taken the rest cure in sanatoria for years without success. They were doomed to die unless surgery in some form would be applied to bring about an arrest of their disease.

HISTORY

The keynote to the advancement of the treatment of pulmonary tuberculosis was sounded by Carson (7) over a century ago when he said, "It has long been my opinion that, if ever this disease is cured, and it is

* From the Department of Surgery, University of Wisconsin. Presented before 89th Anniversary Meeting, State Medical Society of Wisconsin, Milwaukee, Sept. 1930.

an event of which I am by no means disposed to despair, it must be accomplished by mechanical means or, in other words, by a surgical operation." It was not until sixty years later that the practical application of Carson's ideas came to pass. During this time, however, marked improvement in certain cases of pulmonary tuberculosis resulting from spontaneous pneumothorax were observed. To Forlanini (10) and Potain (17) goes the credit of the first application of artificial pneumothorax. Shortly afterwards de C'erenville (7) reported the resection of ribs to obtain the collapse of an apical cavity. Following this, operations were reported by Spengler, Bier, and others. These were not done with the present day plan of attack in mind but were similar enough to be comparable.

The first clear and correct principles applied to the surgical interference in cases of pulmonary tuberculosis were formulated by Professor Brauer (5), an internist of Marburg. The reason for the performance of this operation was Brauer's observance of two types of cases coming under his treatment. In one type he could institute complete artificial pneumothorax and bring about marked improvement or arrest. In the other type he was confronted with the difficulty of being unable to collapse the lung with air because of the presence of pleural adhesions. These cases did not respond well to treatment, and, as no method had been found to overcome this complication, Brauer conceived the idea that the most logical way to overcome the difficulty was to release the imprisoned lung from the thoracic cage by operation. He suggested the performance of an operation for resection of the overlying ribs to his surgical colleague, Professor Friedrich. The first case was that of a Belgian whose condition by all accepted criteria was hopeless. On December 11, 1907, Friedrich performed the operation and removed the entire lengths of the ribs from the second to the tenth inclusive along with the intercostal bundles and the periosteum. The patient recovered and was well sixteen years later. Two or three years later two other German surgeons, Wilms and Sauerbruch, described different types of operations to produce the same collapsing effect as the Brauer-Friedrich operation. Wilms (21, 22, 23) proposed a less radical operation than the first type, which consisted of resection of 2 to 3 inches of the first eight ribs inclusive by the paravertebral route, but he added to this a second stage which was a columnar rib resection along the anterior chest wall. Even though this operation was still somewhat radical, it marked a clear cut departure from the older type. Sauerbruch (18) who had been associated with Friedrich as first assistant and had seen the high mortality rate resulting from his somewhat radical procedure proposed a more conservative type of operation than that of his colleague Wilms. His operation consisted of resection of the first ten ribs by the paravertebral route removing 3 to 4 inches of each. We owe a great deal to these two men for the careful and methodical way in which they reasoned out this operation. Due credit has been given them since the standard operation as it exists today is known as the Wilms-Sauerbruch operation. We must not lose sight, however, of Brauer who formulated the scientific basis upon which the present operation is performed.

In 1891 Tuffier (20) reported an operation which he had performed for the resection of a tuberculous process and stated that it would be a valuable method of applying compression locally by the extrapleural route. Out of this operation has developed extrapleural pneumolysis which consists of the insertion of a plug of bone, muscle, fat, or gauze over a cavity in the lung to bring about its obliteration, the pressure being maintained through the overlying rigid chest wall. This will be referred to later.

The first reference to phrenicotomy was by Stuertz and was practiced simultaneously by Sauerbruch. At that time the operation consisted of simple interruption of the course of the phrenic nerve to produce a paralysis of the hemidiaphragm on the side of the thorax under treatment for tuberculosis. The operation was very disappointing because of the large number of failures. It was found in many instances that the diaphragm was not paralyzed as a result of this operation and consequently the proce-

dure became less frequently used. In 1922 Felix (9) published his results on research of the phrenic nerve. He found various differences existing in the phrenic nerve and its accessory branches in different people. He said that these findings explained the cause of the previous failures and recommended twisting of the nerve and extracting it in its entirety on the theory that all accessory branches would be interrupted. This operation as carried out today is known as phrenicus exairesis. Goetze (11), another worker, recommended finding and dividing all of the accessory branches.

We now find the presence of adhesions preventing the introduction of an adequate artificial pneumothorax as the basis of stimulating another worker to devise an operation to overcome this mechanical difficulty just as Brauer a few years before had been forced to solve the same problem. Jacobeus (14) in 1913 devised an instrument and developed a technique whereby he could visualize these offending adhesions by passing an instrument through an intercostal space. He then, through another opening, divided the adhesion under direct vision. Like thoracoplasty, although in a lesser degree, this has contributed to the surgical treatment of pulmonary tuberculosis.

In 1929 Alexander (3) reported still another operation which he called Multiple Intercostal Neurectomy. He found, upon reviewing the literature, that the operation had been previously used on rabbits by Schepelmann in 1913 and on dogs by Hug. He further states that it was first used on man by Friedrich and Warbot in 1913 and by Bonomo in 1927. Alexander has made a thorough study of the anatomical and physiological effects on animals and man and reported six cases subjected to this operation. The series of cases is small, but the results in some of these were quite striking and along with phrenicotomy the operation gives promise of being a valuable contributory adjunct to surgical treatment.

THORACOPLASTY

What determines the operability of the patient?

Now that surgery has become closely associated with the treatment of pulmonary tuberculosis we must not forget that it is a great departure from the older accepted methods and that its indications are narrow if not absolutely rigid. Once thoracoplasty is performed the effects are lasting and there is no retreat. It has been known for many years that rest is the one goal for which we should strive in the treatment of pulmonary tuberculosis. Rest is the enemy of tuberculosis. Hegner (13) states, "Rest is the foundation of successful phthisiotherapy, and the therapeutic result is proportionate to the degree of rest obtained." In producing functional rest of a lung we are always confronted with a problem as to whether the other lung is going to be able to bear the additional burden imposed by its idle neighbor. It not infrequently happens that this added work is too much, for the so-called good lung already weakened by silent disease lights up with rapidly progressive involvement. Other organs also are affected. The heart is one of the most important of this group since it is so closely associated with the respiratory apparatus. This means then that we must carefully weigh the facts as to whether or not a patient is fit for operation. Patients may be placed in bed, their activity curtailed and thereby a marked degree of rest obtained but this is not always adequate. It then becomes necessary to seek other methods for the production of complete functional rest.

The usual procedure in properly selected cases is to apply more radical means. Usually artificial pneumothorax is attempted and, if successful, accomplishes that for which we have been striving. The collapse resulting from artificial pneumothorax is absolute where successfully instituted. Failure of this method is not uncommon because of pleural adhesions or complete obliteration of the pleural space. Again another method or methods are sought; these include paravertebral extrapleural thoracoplasty, intra- or extrapleural pneumolysis, phrenicotomy or intercostal neurectomy, different types of cases being suited to the different procedures.

The indications for the performance of extrapleural thoracoplasty vary with different authorities only in detail. Brauer (5) determines the indications by asking four

questions. 1. Can the patient recover without it? 2. Will the other side stand the operation? 3. Is the pleura adherent? Test it. 4. Is the general condition and state of the organs good enough?

Sayago (19) feels that thoracoplasty is not indicated until all other treatment has failed and there is no other chance of cure by a less dangerous route.

Lilienthal (15) on the other hand in his own work has not refused to operate on any case referred by a competent phthisiologist, no matter how grave the outlook, provided the opposite lung presents sufficient functioning power to maintain life.

Alexander (1) is more conservative, and the indications to be discussed as applied to our cases are in close agreement with his ideas.

The type of case best suited to surgical interference is the unilateral lesion. The opposite lung should be entirely free from disease or visible evidence of such. To expect this in every case is entirely too much. If, however, a small amount of involvement is present in the apex of the contralateral lung which is of the productive type, non-progressive or inactive, the practical ideal is reached. The lesion in the involved lung should also be of the chronic productive type, cavernous or non-cavernous. It is in these cases that we see a narrowing of the hemithorax and intercostal spaces and a diminution in respiratory excursion. These changes are the direct result of fibrous tissue contraction within the lung in an effort to arrest and bring about healing of the diseased part. The thoracic cage is rigid, and little can be accomplished from this source. The mediastinum, as we know from the studies by Graham (12) on intrapleural pressure, is very flexible and through this property reacts quickly to any change in either lung in the absence of inflammation. It is in these chronic productive cases that the mediastinum, along with the trachea and heart, is markedly displaced and drawn by adhesions to the diseased side. In the cases in which the aforementioned conditions exist we have the "pulmonary indications" for operation. The patient must be considered from other equally important angles. The general condition of the patient should be good. The vital capacity should be checked and compared with the degree of involvement. A thorough study of the differential blood picture should be made with careful leucocytic interpretations over a sufficient length of time to determine the reaction of the patient to the progress of the disease. The presence of an advanced nephritis or diabetes certainly does not make a fit subject. That the heart be in good condition is one of the most important prerequisites. A heart with marked myocardial changes, or a patient with threatened decompensation, would render the operation inadvisable. Patients over fifty or under twelve are usually not considered fit subjects. Tuberculous enteritis or laryngitis, if not advanced and when regarded alone, is not considered a contraindication.

Another type of tuberculous involvement gives a very different clinical picture and includes those cases with marked constitutional symptoms—fever, cyanosis, dyspnoea, and tachycardia. The lesions are of an exudative, non-productive caseous or pneumonic nature. Roentgen rays fail to show any signs of the patient's having thrown up any barrier against the progress of the disease. The disease may appear unilateral, but experience has shown that even with more conservative treatment, such as artificial pneumothorax, new lesions appear in the apparently good contralateral lung and soon the patient has a complete bilateral process. These cases, if given conservative treatment, react much better. Thoracoplasty, of course, is definitely contraindicated. Many of these which respond to conservative treatment under a well regulated sanatorium regime become eligible for operation later as a productive process becomes well established.

Selection of cases for operation would be simple were it not for the borderline cases, and just like all borderline cases they form the outstanding stumbling block. It is these cases which make us wary in our approach and force us to weigh every ounce of evidence for and against operation. Surgery offers rehabilitation and arrest to many such cases; but to get the maximum beneficial results, judgment must be passed only after

careful and watchful care by trained phthisiologists. There is nothing so criminal as the absolute blind plunges taken in some of these cases by individuals incompetent to judge capably the proper prerequisites necessary for radical treatment.

Other conditions may be mentioned in which thoracoplasty is advisable: Recurrent attacks of hemoptysis where artificial pneumothorax cannot be induced and the patient's life is endangered. Certain cases of tuberculous empyema after all conservative methods have failed offer indications. Other non-tuberculous conditions at times warrant this operation.

EFFECTS OF THE OPERATION

The effects of collapse by thoracoplasty are felt from the time of the performance of the operation. The degree of collapse is inferior to that obtained by an artificial pneumothorax, but the immediate reaction is more severe. Artificial pneumothorax when given properly brings about pressure changes slowly, and the constitutional reaction is nil. Following thoracoplasty, whether it is performed in one or two stages, the entire organism must compensate for the marked sudden changes affecting the organs within the thorax. The heart feels these changes more than any other organ. Previous to operation it may have been greatly displaced due to adhesions and its action markedly impaired. In these cases the operation may perform another function other than collapse of the lung. It may serve as a cardiolysis. With the sudden collapse of the lung, retained secretions, pus, bacilli and toxic lymph are expelled into the larger bronchi and the blood stream. This may act in two ways. Firstly, it may rid the body of many toxic products and remove the chances of their further absorption. This in turn reduces the inflammatory process within the lung. Secondly, toxic lymph and blood may be suddenly thrown into the circulation. The effect is only transitory, but at the time when the patient is also suffering from the effects of the operation the combined reaction may be very severe.

The blood supply of the lung is naturally diminished due to the sudden compression of the smaller vessels. Whether there is a secondary hyperemia is a question as yet undecided. Evidence that the collapsed lung is anemic seems logical from the work of Yates (24) in which he states that the unit volume of blood delivered through capillaries is associated with equivalent inflation or deflation of the corresponding alveoli. Certainly a sudden collapse would bring about a marked deflation of the alveoli on that side.

The contralateral lung is intimately involved by the sudden changes in pressure and diminution of vital capacity. The resulting effect is a compensatory emphysema with an increased blood and lymph flow to the part. Following operation one can only institute expectant treatment and supportive measures until a new equilibrium is established. During this period we are not sure just what the result will be. If the shock is too great and the patient's resistance sufficiently lowered, the so-called good lung may light up as the result of an old process, or it may become infected through aspiration of the bacilli laden material squeezed from the sudden collapsed affected lung. If no ill effects are suffered in the good lung, certainly the patient will recover, because toxic absorption is largely eliminated through removal of these products and a lymph stasis persists as a result of the collapse. The patient's resistance increases and day by day, week by week we see the patient grow stronger.

RESULTS OF THORACOPLASTY

The final results of the operation give us some idea of the successes and failures. A large series of cases done by various surgeons using different techniques and as a result of various indications are rather misleading. It is only through the series of cases reported by individual surgeons where they have kept adequate records and have classified each case in a definite group that we can learn just how good or bad are the results.

Two groups of cases have been selected which seem to give a very dependable clue. Archibald (4) reports results on 172 cases and Sauerbruch (18) a series of 117 cases. These authors have used about the same

classification. They have divided them into three groups. The first group is composed of cases with clinically unilateral productive lesions; the second, the predominately productive lesions but with some evidence of disease in the opposite lung; and the third, those in poor condition with rapidly progressive ulcerative lesions.

In the first group Archibald reports 79% clinically arrested; Sauerbruch, 74%. In the second group, Archibald reports 62%; Sauerbruch, 42%. In the third group no arrests were reported, and both report as follows: Archibald, 20% improved; Sauerbruch, 28%. The discrepancy occurring in the second group is probably accounted for by the fact that Sauerbruch reports only arrested and negative sputum cases, while Archibald makes no mention of the sputum but classes them under the group sufficiently improved to return to society. The statistics reported by these two men are remarkably similar, and we can readily see that the results in properly selected cases are very encouraging indeed. The results of the borderline and definitely advanced cases included in group two and three are only fair. Such figures as these should serve as an incentive to us to make further efforts to prevail upon these patients to have the operation done at the optimum time. Once this time has passed, very little can be expected. The immediate operative mortality in patients of type one is low, 1 to 1½%. In two and three it is 10 to 20%, mostly due to spread of the process in the contralateral lung.

EDITOR'S NOTE.—*The second part of this paper, with complete summary, will appear in the next issue of this Journal.*

SECTION ON RADIOLOGY

H. B. PODLASKY, M. D., Editor

Fragilitas Ossium in Twins; Case Report*

By J. NEWTON SISK, M. D.
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Fragilitas ossium is a manifestation of an hereditary character transmitted by either parent without break in antecedent continuity, but which may or may not appear in the immediate descendants. If it does not occur in the next descendants, the character is broken and will not appear again in that strain. Fragilitas ossium, also called osteopsathyrosis, is usually associated with blue sclera and arcus senilis which appear at the earliest age, and is characterized by a slowly developing otosclerosis which appears in the second or third decade.

I present two cases of fragilitas ossium because of the interesting coincidence of its occurrence in twins. They are girls, age four, two of five children all others of whom are normal. The general development of these two is normal for children of this age; the diminutive stature is but apparent from shortening of the thighs for reasons to be observed on the x-ray film herewith presented. Considering the handicap under which locomotion is attained, they walk around remarkably well but without apparent use of the hip joints. The eyes of each are distinctly characterized by narrow arcus senilis and there is a faint but inconspicuous bluish tint in the sclera.

Roentgen examination was made of the skeleton of each of these children. This reveals in one old fractures of both femurs in the upper thirds with non-union and conspicuous deformity; fractured left humerus at the middle of the shaft which is united at right angles, and the eighth rib on the left is fractured with non-union. The films on the other child show fractures of both femurs at the same level as in the first also with deformity and non-union. This one also has old fractures of the seventh, eighth and tenth ribs on the left and the eighth rib on the right, all of which are united.

* Presented at the meeting of the Radiological section, State Medical Society, at Green Bay, May 23, 24, 1930.

Fragilitas Ossium in Twins.

Each of these injuries occurred at different times before the children became two years of age, and resulted from such trivial trauma that they were not observed for some days afterward when the deformity of the limbs appeared.

This manifestation in these children cannot be traced farther back than the previous generation and is continued through the pa-

Fragilitas Ossium in Twins. X-ray film of femora in each case shows the same conditions as in this illustration.

ternal ancestor. The sclera of the mother is clear white; there is no evidence of arcus senilis; she is beyond forty, but has no defect in her hearing. She knows of no injury to herself nor to any member of her family, although she remembers frequently having experienced considerable trauma from falls. Both eyes of the father show distinct arcus senilis and the sclera have a bluish tint which is not conspicuous; he has definite progressive bilateral otosclerosis which is practically complete on one side. He relates an instance of having a leg broken from a rather trivial cause.

THE JOURNAL CLINIC

Acromegaly, With Associated Conditions; Clinical Findings and Therapy of a Case*

By WILLIAM H. OATWAY, Jr., M. D.
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A most interesting syndrome in endocrinology is that in which acromegaly, the result of a hyperplasia of certain cells of the anterior lobe of the pituitary body, is the chief sign, and in which there is an allied disturbance of function, and possibly histological structure, of the thyroid, the ovaries, and the pancreas.

* From the Department of Medicine, University of Wisconsin.

Since the first description of the condition of acromegaly in 1886 by Marie, the greatest advance in the study of pituitary function has been a study by Cushing in 1909,[1] in which he named hypo- and hyperpituitarism and differentiated them by clinical and experimental work. In 1927[2] he performed necropsies on four cases and noted constantly an overgrowth of mesodermal tissue, a disproportionate splanchnomegaly, general polyglandular anomalies with tendency to adenomatosis, and a central hyperplasia or adenoma of the hypophysis, with all of its cells containing acidophilic granules. In 1928 Evans[3] and his co-workers produced gigantism in rats by parenteral injection of an extract of the anterior lobe of the pituitary body and in 1929 Putnam[4] accomplished the same phenomenon in dogs.

Cushing and Davidoff[5] (1927) believe that acromegaly has the same relationship to pituitary insufficiency (hypopituitarism) that exophthalmic goitre bears to myxedema (hypothyroidism). Acromegaly is often accompanied by symptoms suggesting a thyrotoxicosis, an increased basal metabolic rate, as well as a palpable thyroid to which the high rate has been ascribed. They believe, however, that the chromophilic cells of the anterior lobe secrete a substance which contains a hormone of growth, but which also is capable of raising the basal metabolic rate. This may act directly or through an effect on the thyroid, for thyroidectomy and Lugol's solution lower the rate. Histologically the thyroids show only the colloid changes of adenoma without evidences of toxicity.

Again,[6] they feel that in addition to the above function and the diminishing of the functional activity of the gonads, the pituitary causes a diminished power of metabolizing carbohydrates, generally considered a function of the pancreatic islets only. Acromegaly has a lowered sugar tolerance, often a hyperglycemia, although not always a glycosuria. The condition responds to insulin, as does thyrotoxicosis to Lugol's, but neither respond as well as though uncomplicated by acromegaly. Extirpation of the hypophyseal tumor will both lower the basal metabolic rate and the hyperglycemia.

The general clinical appreciation of that time and since was voiced by Osler and McCrae,[7] in 1922, when they referred to the more or less constant association with acromegaly of diabetes, especially in the early stage; goitre; myxedema or flabby obesity; and amenorrhea. Davidoff[8] in a statistical study in 1926 noted the onset of acromegaly to be from 18 to 35 years of age. He found a twenty per cent family history of large individuals; that the menses usually ceased at an early age; and that the symptoms of the condition were related to the seat of the disease.

CASE REPORT

This report may be of interest because of the classical completeness of the syndrome:

The patient, Mrs. S., married, white female, 49 years of age, was admitted to the Wisconsin General Hospital on May 3, 1930. Her chief complaint at that time was numbness of the feet.

The history of her present illness began six years ago, when at the age of 43, the patient noted that she had become clumsy and had difficulty in coordinating her movements. Five years ago she noted the onset of an extreme weakness and a thinness of her face and loss of weight. At the same time she noted polydipsia, polyuria and incontinence. She went to a clinic where a diagnosis of diabetes mellitus was made and she was given a diet and instructions which were followed sporadically or ignored since that time. For the next few years she gradually became less strong, had several localized skin infections, and in 1928 she first noticed anaesthesia and coldness of her feet. In applying heat to them they were blistered, healed, blistered again in 1930, and at that latter time the fourth toe of the left foot did not heal.

At the onset and shortly before they were removed, the patient noted that the teeth in her lower jaw were "spaced." Her menstrual history had been very regular until five years ago, when at the age of 44 she suddenly stopped menstruating. There had been no bleeding since then nor has she ever had any hot flashes. Her average weight formerly was 212 pounds. In the summer of 1928 she weighed 174 pounds and at the time of admission 165 pounds. For the past few years she has had an occasional palpitation and dull precordial pain. In the summer of 1930 there was an acute inflammation of both eyes. Since then she had noticed that they were inflamed intermittently. Other symptoms included an occasional vertigo, amblyopia and diaphoresis. She had had a severe pruritus vulvae which was aggravated by scratching. For the past few months when the blisters on the left foot failed to heal, the left leg had been swollen; her voracious appetite had caused her re-

Figure 1.

cent indigestion and for two weeks the patient had vomited early in the morning and had felt nauseated during the day.

The only diseases in the past medical history were measles, diphtheria, and jaundice in childhood. The patient's father was living and the mother had died of heart disease. There was no family history of diabetes or physical deformity, but the mother and father were both of very large frame size, though they were not fat. The patient had one brother and two sisters, all very large. One sister was very fat, weighing 280 pounds, but was well. The patient had had ten children, nine were living and well, their ages being 17 to 32 years. The last one was born when the patient was 32 years of age. One child died of congenital heart disease. The patient had two miscarriages (first one after the fifth child, second one two years after the last child, at the patient's age of 35 years).

(Additional history from a daughter stated that the family had noted a change in the mother's features. The date of onset was not definite, but approximately five years ago. They noted that the nose and the whole face seemed much larger. She stated also that so far there was no change in appearance of any other member of the family).

Physical examination: Patient was an elderly appearing female, lying apathetically in bed. Her right eye was inflamed to a brilliant red over the entire conjunctiva, as was the left eye but to a lesser degree. The conjunctiva on the right, where the inflammation was most noticeable, was somewhat thickened. There was a slight exophthalmos but no lid lag. The features were all increased in size especially the nose and the lower jaw which protruded forward. The lips were large, the pupils were unequal and the right pupil was decreased in size and did not react to light and accommodation. There was a tenderness over the left frontal sinus and the septum obstructed the nasal passage on the right side of the nose. A marble-sized, hard nodule was palpated at the right temporo-mandibular articulation on the anterior edge of the glenoid fossa.

The lips were pale and gross and the patient had an upper and lower dental plate. The tongue was very long, grossly furrowed, and with hypertrophied papillae. It was almost a beefsteak red in color. The tonsils were markedly enlarged and cryptic and the pharynx was injected. The neck was grossly enlarged and there was a nodular mass, the size of an orange, in the position of the right lobe of the thyroid. The isthmus was also slightly palpable, and there was a systolic murmur heard over the lobe. The lungs were normal except for a few basal rales. The heart showed an increase in cardiac dullness 5 cms. to the right and 11 cms. to the left of the midline in the 5th interspace. There was an increase in the size of the supracardiac cap and there was an impulse in the second interspace on the right. The tones were of moderately good quality and rhythm was regular, and there was a tachycardia,—heart rate being 96. There was a systolic murmur, soft and blowing, at the apex and left base. Blood pressure was systolic 146 diastolic 100. The peripheral arteries were thickened and beaded.

The abdomen was pendulous and large; no fluid could be demonstrated, and the liver was palpable 4 cms. below the costal margin in the midclavicular line. The skin was loose and dry.

Examination of the extremities showed that the hands and feet were short and thick. The digits had a spatulate appearance and there was an enlargement of the great toe of each foot. The skin was dry, loose and flabby over the arms and legs. There was edema of the left leg as far as the knee. The fourth toe of the left foot was enlarged, swollen and ulcerated and there were draining sinuses on the dorsum. There was a painful swelling extending two inches above the metatarsophalangeal junction. The dorsalis pedis pulse was felt bilaterally. There was no tremor of the extended hands and the deep and superficial reflexes were all present. The vibratory sense was normal. The patient was not able to walk. (Fig. 1.)

Laboratory Examinations: A blood sugar taken at the time of admission was 255 mgs. per 100 cc. of blood. There was a marked glycosuria throughout the day and traces of albumen and acetone were found in the urine; the urine also showed many white blood cells in voided specimens. A complete blood count gave a hemoglobin of 70 per cent, red blood cells 4,200,000, white blood cells 15,700 with 70 per cent neutrophiles, 23 per cent lymphocytes, 5 per cent large mononuclears and 2 per cent eosinophiles. The blood Wassermann was negative and

the nonprotein nitrogen content of the blood was 31.2 mgs.

A glucose tolerance test, done on May 13th showed an initial blood sugar of 232 mgm. Following the ingestion of 50 grams of glucose this rose in one-half hour to 270 mgm.; in one hour to 285 mgm.; in two hours it declined to 277 mgm.; and in three hours to 259 mgm. At the time of the last readings there was a ++++ glycosuria. This result is typical of diabetes mellitus.

Basal metabolic tests were taken at weekly intervals. The first series gave a +10 and +12 per cent, with a pulse rate of 72 to 78 (on May 14th); second +19 and +21 per cent with a normal pulse (on May 20th); the third (on the 29th of May) a reading of +13 and +14 per cent with a pulse of 66 to 72 a minute.

Roentgenograms of the foot showed that the bony structure of the fourth toe was practically disintegrated. There was a moderate hypertrophic arthritis of the great toe and a large spur on the medial aspect of the distal phalanx. There was noted a marked arteriosclerosis. A stereoroentgenogram of the chest showed the heart to be transverse in location, with an apparent widening in this diameter. There was a definite widening and elongation of the arch of the aorta. There was no parenchymatous change in the lung fields.

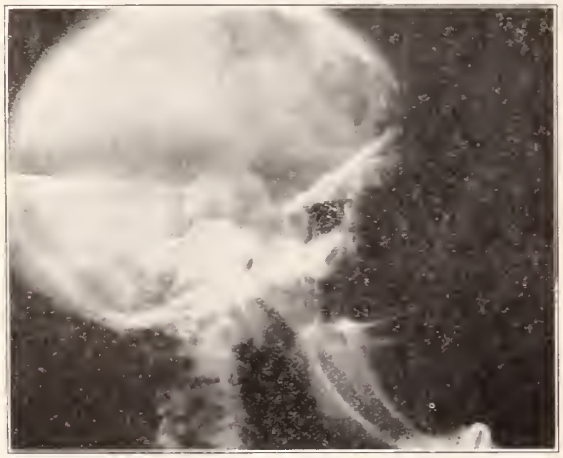

Figure 2.

There was a spurring from the lower surface of the 4th and 5th ribs anteriorly on the right and some narrowing of the interspaces bilaterally. Three stereoroentgenograms of the skull were made. These showed that the bones of the skull were markedly thickened; the mandible was enlarged and projected, the sella turcica appeared markedly enlarged and seemed as though there were bony union over the top with small calcific shadows scattered through the middle portion, the appearance being that of a bony cyst. (Fig. 2.) A special examination was made of the eye grounds, which were seen to be normal. The visual fields were examined and there was a constriction in the temporal regions of both eyes.

Primary Diagnosis:

1. Acromegaly, with a tumor of the pituitary body. Accompanying this there were
2. Diabetes Mellitus
3. Adenoma of the right lobe of the thyroid
4. Obesity
5. Gangrene in the left foot, with edema of left leg
6. Conjunctivitis and iritis of both eyes
7. Arteriosclerotic cardiovascular disease with
   - Cardiac hypertrophy and dilatation
   - Relative mitral insufficiency
   - Dilatation and elongation of arch of aorta
   - Passive pulmonary congestion
8. Bitemporal contraction of visual fields
9. Chronic rhino-pharyngitis with diseased tonsils.

Again referring to Osler and McCrae,[7] a synopsis of symptoms is given, with special reference to presence in this case, and a classification according to mode of involvement.

The Regional Symptoms:

Headache +
Somnolence +
Deafness +
Epistaxis +
Rhinorrhea 0
Irritability +

The Eye Symptoms:

Exophthalmos +
Pressure on nerve +
Nerve atrophy 0

Perversion of Secretion Symptoms:

Tissue growth
Face +
Hands +
Feet +
Fat +
Subcutaneous +
Skin +
Lined palms +
Eyelids +
Tongue +
Jaw with prognathism +
Teeth spacing, lower jaw +
Periosteal growth +
Sella Turcica +
Bones +

The symptoms are thus seen to be almost all present, as are the conditions associated with acromegaly mentioned by the same authors, and by Davidoff and Cushing.

Progress: The diabetic condition was controlled with some difficulty. The patient had an insatiable appetite and it was finally necessary to give her 60

grams of protein, 80 grams of carbohydrate and 190 grams of fat. She was practically sugar free on this diet with 25 units of insulin in the morning, 15 units at noon and 20 units before supper. Her blood sugar before breakfast was constantly about 210 mgs. at that time. Infection of the foot was taken care of by an incision and free drainage, followed by hot, wet packs, and later dry heat. The swelling of the leg immediately subsided and the condition of the foot was greatly improved at the time of discharge. The condition of the eyes was given special attention, and after several weeks of care the conjunctivitis and iritis were practically cleared, allowing free dilatation of the pupil and relieving the patient symptomatically.

Additional information was obtained, at the time of discharge, from the husband of the patient who stated that his wife had brought a son to the hospital five years ago, and at that time Dr. Burns of the orthopedic department had noted the facies and appearance of the patient, suggesting an x-ray of the skull, and following this she was told that she probably had an intracranial tumor. This roentgenogram was obtained and it showed the same thickened cranial bone, and the calcified cystic tumor in the region of the sella, although this was smaller than that seen in our present series of films.

Treatment: After a conference with the surgical staff, it was suggested to the patient that an operation with the removal of the growth was a certain way of stopping the progress of the disease and allaying the effects of the secondary conditions. Operation was refused.

X-RAY TREATMENT

The roentgen-ray treatment of tumor of the pituitary body is a comparatively recent undertaking, and by far the greatest number of reports are in the foreign literature. Early reports on the use of deep radiation in reducing the size of pituitary tumors are those of Beclare[9] in 1922 and Towne[10] in 1924. Cushing[11] in 1927 states that, although deep radiation is a means of control, it is no substitute for operative removal.

Dr. Hans Magnus[12] treated 34 cases of pituitary tumor by deep radiation, getting his best results on anterior lobe tumors with acromegaly. The results were best shown by examination of the visual fields. He states that the tumors in acromegalics are benign. Heinismann and Czerny had their best success in the same type of case. Henser and Lauber gave sensational restoration of restricted visual fields by roentgen-ray therapy. Bremer, Coppez and Iluys use radiation only on inoperable cases. Magnus quoted nine continental clinicians who had good results by radiation. Hoffmann collected 90 cases, 69 of which were improved after roentgen-ray therapy. Stock had 50–70 per cent good results in his series.

Wintz[13] reports a case of hyperpituitarism with acromegalic changes which was treated by x-ray (80 per cent H.E.D., two times in one month) and there was a resumption of menses, normal facies and fat. The reduction of vision remained, however.

Allen and Lisser[14] reported a case in 1928 of a woman with acromegaly and diabetes. There was no restriction of visual fields, the basal metabolic rate was normal and the sugar tolerance was greatly decreased with a marked hyperglycemia present. An intensive course of deep radiation therapy produced symptomatic relief, an eventual decrease of metabolic rate, and a notable progressive drop of the dextrose tolerance curve towards normal over a period of five observations.

Deep x-ray therapy was recommended to our patient and to this she consented. In consultation with Dr. Pohle therapy was given from four areas

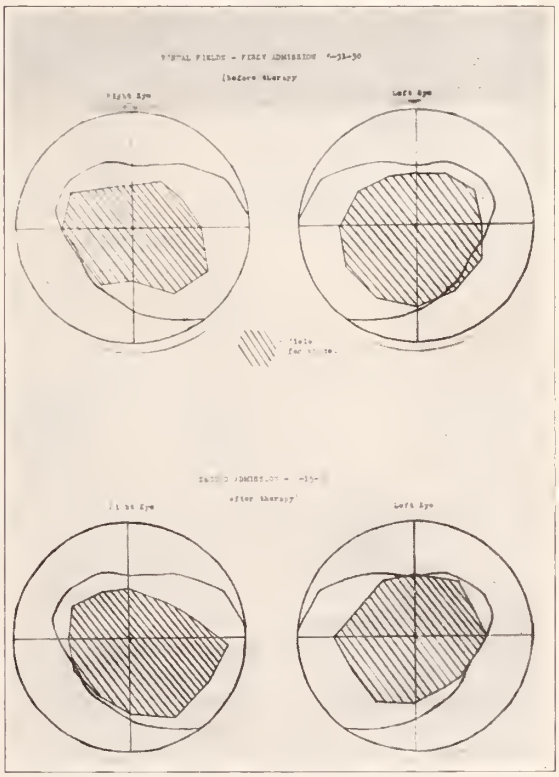

Figure 3.

of approach, the right and left temporal, the occipital and the frontal regions, the rays being centered on the pituitary body. She received 725 R. in four treatments during a period of five days; 800 R. a week later, during a four-day period; and 800 R. during a two-day period a month later.

This amount of radiation in six weeks is about 125 per cent of an "erythema dose," or well above that necessary to treat intensively tissue at the depth of the pituitary body. It could not possibly constitute the much questioned "stimulating dose." The amount used in this case was only slightly less than Allen and Lisser used in six months on their case.

The condition of the patient did not change following the first course of eight exposures, either symptomatically or as shown by careful plotting of the visual fields. (Fig. 3.)

Any slight variation here can be attributed to accident or education. The general condition had improved and after the second course of radiation, and training in diabetic self-care, the patient was allowed to leave on 7–30–30.

Readmission: The patient returned on 8–25–30 and remained for three days while she was reexamined. She had, as before, allowed trifles to interfere with her diabetic care and insulin had not been taken for several days previous to admission. She had been asymptomatic except for headaches during those few days and an increased amblyopia.

There was no change physically except for a slight weight loss to 151 pounds, and a further healing of the left foot.

Laboratory tests showed 16.8 gms. of sugar in the urine in the first 24 hours and a blood sugar of 375 mgm. per cent on admission. Basal metabolic rates were +46 and +42 per cent. A glucose tolerance test was done and is compared here with the earlier one:

	8–27–30	5–13–30
Fasting	307 mgm.	222 mgm.
50 gms. glucose intravenously		
30 minutes	322	270
1 hour	380	285
2 hours	363	277
3 hours	298	259

A stereoroentgenogram of the skull failed to show any change.

The visual fields were again plotted and were approximately the same as on the two previous occasions.

It was decided that enough radiation had been given. The patient was discharged with advice to her physician that if further decrease in vision occurred, surgery might be urged. The nature of the patient probably will not permit further opportunity for study, and attempts at correspondence since discharge have met with no response.

COMMENTS

This case of acromegaly has shown an unusual completeness in its anamnesis and in the inclusion of allied conditions.

Theoretically and from experience of others, deep radiation to the pituitary body should have caused an improvement in the size of the visual fields, an improved sugar tolerance, a lowered basal metabolic rate. It is entirely possible that the type of tumor, seen to appear as a bony cyst, which had enlarged only slightly in five years, precluded a lessening of pressure on the optic nerves. The presence of synechiae may also have affected the accuracy of the perimeter test. The elevated metabolic rate and sugar tolerance curve might be discounted by the condition of the patient on the second admission following poor dietary control. There were, however, no effects on the signs of local pressure or on the results of perverted secretion comparable to those obtained by other workers in similar cases.

There is no doubt but that a later study of this case would be of worth in further evaluating the results of therapy.

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Acute Subarachnoid Hemorrhage; Report of Two Cases

By J. A. EVANS, M. D., and
ALICE D. WATTS, B. A.
La Crosse

Within the past two years two cases of acute subarachnoid hemorrhage have been diagnosed at St. Francis Hospital. Both of these cases occurred in young adults in whom the onset of the condition was sudden with severe headache, vomiting and vertigo. Symmonds who has reviewed the subject from the point of view of anatomy, pathology and clinical classification states that in his opinion intracranial aneurysms are a commoner cause of spontaneous subarachnoid hemorrhage in young people than is generally supposed. The cause of such intracranial aneurysms is still unknown but the suggestion has been made that they are due either to a congenital defect in the wall or to a local infective or degenerative process. Clinically, the symptoms vary according to the location and the amount of the hemorrhage and in all cases result from the mechanical effects of the hemorrhage. The changes in the cerebrospinal fluid as summarized by Symmonds are more constant, macroscopic characteristics of which are: 1. An even admixture of blood which is the same in a series of specimens collected; 2. Absence of coagulum; 3. Orange, brown, or yellow coloration of the clear supernatant fluid apparent when the red cells have been allowed to sink to the bottom of the tube.

FIRST CASE

Case 1. A woman, aged 28, entered the hospital February 8, 1929, giving a history of having had influenza and pneumonia six weeks previous to entrance followed by a silght cold ever since. On admission she complained of a severe headache with some vomiting, vertigo, backache and cramps in the right leg. A history of chronic cough, night sweats, chills and fever was elicited. Physical examination showed definite stiffness of the neck, and positive Kernig bilaterally. There were no cranial nerve palsies, tache cerebrale or pathological toe signs. Mentally she was usually sane, but occasionally her memory and statements wandered. In other respects the physical examination was negative. The spinal fluid at first was very bloody and was under increased pressure. Culture of the spinal fluid showed no growth and no coagulum formed on standing. The patient was tapped every two or three days, the amount of blood being definitely less every day until on discharge there was only xanthochromia. The pressure of the spinal fluid correspondingly decreased and the spinal fluid cell count dropped from 110 on entrance to 48 on discharge. A negative Wassermann test on both spinal fluid and blood ruled out lues as a possible etiological factor. The whole course of the patient's illness was afebrile. The headache and backache persisted for a period of two weeks. The patient felt better immediately after each lumbar puncture, and was discharged on February 21st, very much improved clinically.

SECOND CASE

Case 2. A high school student in St. Rose convent, aged 19, complained of a severe headache beginning on January 1, 1931. At the same time she noticed a sensation of numbness all over her body with pain in the lower back and left leg. The headache became progressively worse and was associated with vomiting, vertigo and diplopia. She was admitted to St. Francis Hospital the next day with no decrease in the severity of the headache.

Physical examination revealed a well developed young adult female, apparently in severe pain but quiet and rational. There was rigidity of the neck with pain on passive movement and tenderness to palpation over the occipital and frontal regions. Kernig's sign was positive bilaterally. There was weakness of convergence of the left eye but otherwise the extraocular movements were normal and there was no nystagmus. Fundi were normal and pupils reacted to light and accommodation. Blood pressure was 104/60 with pulse rate of 72. Patellar and Achilles' tendon reflexes were hyperactive and on the second hospital day jerking movements of both legs were noticed. There was no patellar or ankle clonus. Slight facial asymmetry was noticed on the left side on the second day otherwise cranial nerves were intact and the Babinski and confirmatory signs were negative. Romberg was negative. The temperature chart showed a low grade type of fever. Lumbar puncture done on January 3rd showed an evenly distributed bloody fluid under normal pressure. No coagulum was formed on standing and the fluid became clear when centrifuged. Cell count was not made on account of the blood. Culture was made but contamination was reported. Clinically there was slight temporary improvement after lumbar puncture. Spinal fluid was uniformly bloody again on January 5th, and no coagulum was formed. However, the fluid became slightly straw colored when centrifuged. Lumbar puncture repeated again two days later showed a marked decrease in the amount of blood present. Culture made was negative. Urinalysis revealed a slight trace of albumin. Hemoglobin was 73% with 4,050,000 RBC and 12,750 WBC. The stereo of the skull was negative.

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EDITORIALS

EARLY DIAGNOSIS CAMPAIGN

THE approaching (four annual) EARLY DIAGNOSIS CAMPAIGN should have unusual interest for the medical profession. In the first place, some of the cumulative value that there must be in the annual recurrences of these educational campaigns among the lay public, ought to begin to manifest itself in an increased number of patients presenting for examination. In the next place, this year's campaign centers on a very interesting age group as concerns tuberculosis, viz., boys and girls of high school age.

It is at this age period that tuberculosis begins to manifest the viciousness and the deadlines which become so overwhelming during the immediately succeeding age periods. Thus in Wisconsin, a study of the past three years' mortality statistics shows that tuberculosis was the chief cause of death among girls in the 15 to 19 year age group and was responsible for 29% of all their deaths. While accidents are responsible for somewhat more deaths among boys at this age, tuberculosis ranks second and is the chief *disease* cause. It accounted for 14.6% of the total number of male deaths between the ages of 15 and 20.

As has been explained before, the object of the tuberculosis associations is to concentrate attention among the laity throughout the Nation on the subject of tuberculosis, and to bring as many potentially tuberculous individuals as possible before the "judgment seat" of the medical profession.

April is a singularly appropriate season for such an EARLY DIAGNOSIS CAMPAIGN *roundup*. The two most deadly months of the year for the tuberculous are ordinarily March and April. Perhaps it has been largely for this reason that more living cases are commonly reported to the health authorities at this time of the year than at any other season. It would appear also that the traditional spring "tired-feeling" brings patients to the consulting room where tuberculosis can be disclosed. H.E.D.

CASE HISTORIES

WE are printing elsewhere in this issue a brief article on the writing of medical histories which we should like to believe every younger member of the Wisconsin medical profession, at least, will read and re-read. In the first place, it is easy reading, because it comes from the pen of one of the best literary medical men on the American continent. In the next place, we are convinced that there is more of genuine medical wisdom in these few brief paragraphs than can be found in many tombs of medical writings by mere medical technicians.

It has been said so many times that the practice of medicine is an art as well as a science that the words seem largely to have lost their significance through contemptible familiarity. That is too bad. But we must

keep on repeating because no physician can become a really good physician until this truth sinks in and is absorbed as a part of him. As a rule, an artist becomes such only through practice, and while something beside practice is required to make an artist, we are convinced that if more young men practiced the art of writing medical histories in the spirit Stewart is attempting to inspire, we should have more physicians of the caliber of Osler, S. Weir Mitchell, and Trudeau, notably, who were physicians first, last and always, and medical scientists as an unescapable corollary. H.E.D.

SPEAKING OF DOCTORS

AS A bit of sweetening to those whose nerves have been frazzled by articles in the lay press critical of the doctor, we recommend "Dr. Serocold" by Helen Ashton.

Here is a very interesting novel which cannot but please the medical taste. One day of the experience, thoughts and recollections of a rural English physician. Not too English to find its counterpart in the life of an American and not too rural to interest a city doctor. H. E. D.

THE COUNCIL ON PHYSICAL THERAPY

IN 1925 a resolution was adopted by the House of Delegates of the American Medical Association asking the Board of Trustees of the Association to appoint a Council on Physical Therapy composed of physicists, pathologists, physiologists, and clinicians whose duty should be to investigate and report upon the merits or demerits of various types of physical therapy apparatus offered for sale to the profession.

It was apparent that many articles were being manufactured and sold under claims that were in some cases grossly overrated and in others entirely fraudulent and that the average physician had neither the time nor the technical skill to determine the correctness or falsity of these claims.

The Board of Trustees at once took up the matter and, as soon as a Council was appointed, work along the lines suggested by the resolution adopted by the House of Delegates was commenced. There were, of course, many details of organization, methods of procedure, etc., that had to be worked out before the real work of the Council could be started.

The cooperation of the Bureau of Standards at Washington gave to the Council the assistance of the trained physicists and technicians and furnished the facilities for investigating the various types of apparatus on the market. The work of the Council has developed slowly and carefully along definite and fundamental lines. Reputable manufacturers of apparatus were willing from the first to cooperate with the Council and to limit their advertising claims to the facts as determined by the Council's investigations. Reports upon apparatus put out under false or fraudulent claims have been published and this work is still being carried on. Physicians may now be assured that the Council on Physical Therapy is in a position to give definite and accurate advice as to the correctness or falsity of claims made by the manufacturers of apparatus, and the medical profession should make use of the information which the Council has accumulated. J. F. S.

POLITICAL INTERFERENCE

A RESOLUTION calling for the removal of political interference in public health service was adopted by the American Public Health Association at its annual convention.—News Note. Strange it never occurred to anybody to apply that remedy before. We wonder what the politicians have resolved. H. E. D.

HOSPITAL TRAINING OF INTERNS

HAROLD L. FOSS, Danville, Pa. (*Journal A. M. A.*, March 28, 1931), maintains that irrespective of how well organized the intern service may be and of how great the effort put forth by the heads of departments to render the training of the most practical value, the greatest accomplishment will not be achieved without a certain basic principle being borne in mind. The young physician fresh from the medical school and entering his intern service begins now to practice more of the science than of the art of medicine. He is in the most formative period of his existence, keen to learn, wide-eyed and enthusiastic, trusting and hopeful, relying tremendously on the guidance of his chiefs, so much so that it places a great responsibility on them the significance of which none too frequently bear in mind. The student acquires a sense for scientific work only in his student days, and the degree of scientific training and interest imparted to the young man in the medical school (*and hospital*) determines his intellectual level for the rest of his life. Clinicians should fully appreciate their obligations as teachers, realizing that their rôle is hardly second in importance to that of the men who have guided the student during his college years and that it is their privilege by their precept and example, by their opportunity to stimulate his latent enthusiasm, by the inspiration of their own personalities to afford him in the most important phase of his professional career that guidance so important in molding and shaping and directing his destinies to the end that his life becomes a failure or a success largely as the clinicians choose to make it.

THE PRESIDENT'S PAGE

C. A. Harper

APPENDICITIS—WHY?

THERE is no evidence that the anatomical structure of the normal appendix has changed. Why then should deaths from appendicitis be on the increase? Is it because it has not been included in the usual public health educational campaigns and people have become indifferent? Or is it because our civilization as we understand it is receding? Is life of less value and of less importance than formerly? What relationship does the movie, the automobile, bridge, golf, the telephone, bear toward the proper care of the sick and especially abdominal pain indicating possible appendicitis? How are the various fads and cults affecting the death rate from appendicitis?

Undoubtedly modern customs have a marked bearing on this wholly unnecessary increase of a disease that parallels cancer as a cause of death in people under fifty years of age. It cannot be questioned but what surgical technique has improved. Hospitals are available throughout the country. Nurses are more efficiently trained. The machinery for efficiently handling acute cases of appendicitis was never better. The cause, therefore, cannot be laid to methods of general surgical procedure at the time of operation.

In every decade of life there is an increase of mortality from appendicitis except the period from ten to nineteen years of age. Gastro-intestinal diseases of childhood of the old, universally prevalent type have almost been eliminated, thereby making a diagnosis of appendicitis less complicated. It appears, therefore, that there must be some underlying cause, universal in type, that should be given serious consideration.

The most recent and acute increase appears to come from the Pacific coast. "Dr. William Brady has commented recently on the observation of a medical writer from Oregon who had accounted for the enormous increase in that section as being in part due to delay caused by messing with cults and quacks who are thriving on the Pacific coast more than anywhere else in the country."

An eastern state, however, had an "increase of eleven hundred deaths in 1928 over any previous year." Delay in consulting a physician, having an early diagnosis made and immediate operation by a competent surgeon is probably fundamentally responsible. There is no active medical treatment for appendicitis. Hospital records show that of cases operated within twenty-four hours after onset 2.63% died; forty-eight hours after initial symptoms 5.54% failed to recover; seventy-two hours delay caused 7.02% failure; after seventy-two hours the death rate was 10.7%. For those who recovered the average lapse of time between onset of symptoms and operation was 59.1 hours. For those who died the lapse of time was 100.5. Eighteen thousand deaths annually from appendicitis indicates a serious situation especially when the vast majority of these deaths could have been prevented if modern scientific procedure were put into effect. The responsibility for this unnecessary loss of life may be general. The medical profession may be able to determine the underlying causes concerning the increase of this 30 to 40%.

Castor oil or other laxatives may be members of the group of asssassins that affect the mortality from appendicitis. Home medication may be a serious factor.

Again, consideration should be given to the practice of hospitalization of acute illnesses of this type. It is difficult to say how many appendices may have been ruptured as a result of the transportation of an acute case of appendicitis from a rural home to a hospital. Some physicians have claimed this to be a most material factor. The extra exertion on the part of the patient after an appendix has ruptured is claimed to disseminate the infection by breaking down the barriers of the natural resistence. It has not been so long ago that appendicitis in the rural district was operated in the home. Today such a procedure is vastly an exception to the rule. There is enough basis for argument along these lines to give the procedure the most serious consideration.

The readiness with which a serious appendiceal condition may arise in children with apparently mild clinical symptoms is well known to the medical profession.

Diphtheria antitoxin administered in proper doses within twenty-four hours after the onset of the symptoms reduced the mortality in diphtheria to almost a negligible minimum. The same principle is applicable to acute appendicitis that early diagnosis, early operation by a competent surgeon is the first big factor in bringing about a reduction of deaths from appendicitis. The internist and surgeon are equally concerned.

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T. W. NUZUM, Janesville
M. D. BIRD, Marinette

Committee on Public Policy

OTHO FIEDLER, Sheboygan, Chairman
S. M. B. SMITH, Wausau
C. S. HARPER, Madison

Committee on Medical Defense

A. J. PATEK, Milwaukee, Chairman
W. C. BECKER, Watertown
F. G. CONNELL, Oshkosh

Committee on Health and Public Instruction

W. D. STOVALL, Madison
C. M. GLEASON, Manitowoc
H. M. STANG, Eau Claire

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LIST OF EXECUTIVE OFFICERS OF COUNTY MEDICAL SOCIETIES

County	President	Secretary
Ashland-Bayfield-Iron	W. J. Tucker, Ashland	J. W. Prentice, Ashland.
Barron-Washburn-Sawyer-Burnett	J. H Wallis, Rice Lake	E. R. Hering, Shell Lake.
Brown-Kewaunee	A. J. McCarey, Green Bay	E. S. Knox, Green Bay.
Calumet	A. C. Engel, New Holstein	A. F. Slaney, Hilbert.
Chippewa	F. T. McHugh, Chippewa Falls	J. A. Kelly, Chippewa Falls.
Clark	M. McGonigal, Loyal	E. L. Bradbury, Neillsville.
Columbia	A. J. Batty, Portage	H. E. Gillette, Pardeeville.
Crawford	A. J. McDowell, Soldiers Grove	C. A. Armstrong, Prairie du Chien.
Dane	F. J. Hodges, Madison	L. V. Littig, Madison.
Dodge	E. P. Webb, Beaver Dam	A. W. Hammond, Beaver Dam.
Door	John Hirschboeck, Forestville	C. H. Christiansen, Superior.
Douglas	J. W. McGill, Superior	P. G. Spelbring, Eau Claire.
Eau Claire and Associated Counties	E. E. Tupper, Eau Claire	H. R. Sharpe, Fond du Lac.
Fond du Lac	H. A. Devine, Fond du Lac	M. B. Glasier, Bloomington.
Grant	E. A. A. Dunn, Platteville	J. F. Mauermann, Monroe.
Green	W. B. Gnagi, Sr., Monroe	A. J. Wiesender, Berlin.
Green Lake-Waushara-Adams	J. M. Johnson, Ripon	H. M. Walker, Dodgeville.
Iowa	T. A. Hagerup, Dodgeville	M. G. Peterson, Lake Mills.
Jefferson	Will Young, Ft. Atkinson	A. T. Gregory, Mauston.
Juneau	C. A. Vogel, Elroy	W. H. Lipman, Kenosha
Kenosha	W. H. Bennett, Kenosha	R. L. Eagan, La Crosse.
La Crosse	W. J. Jones, La Crosse	W. B. Williams, Argyle.
Lafayette	R. B. Quinn, Darlington	J. C. Wright, Antigo.
Langlade	E. J. Donohue, Antigo	W. H. Bayer, Merrill.
Lincoln	E. K. Morris, Merrill	C. H. Barnstein, Newton
Manitowoc	W. G. Kemper, Manitowoc	Verne E. Eastman, Wausau.
Marathon	Joseph F. Smith, Wausau	M. D. Bird, Marinette.
Marinette-Florence	T. J. Redelings, Marinette	Theo. Wiprud, Ex. Sec'y, Milw.
Milwaukee	E. L. Tharinger, Milwaukee	H. H. Williams, Sparta.
Monroe	A. E. Winter, Tomah	G. W. Krahn, Oconto Falls.
Oconto	R. J. Goggins, Oconto Falls	I. E. Schiek, Rhinelander.
Oneida-Forest-Vilas	C. D. Packard, Rhinelander	R. V. Landis, Appleton.
Outagamie	J. L. Benton, Appleton	A. E. McMahon, Glenwood City.
Pierce-St. Croix	J. H. Armstrong, New Richmond	Geo. B. Larson, Frederic
Polk	L. O. Simenstad, Osceola	H. P. Benn, Stevens Point.
Portage	F. A. Marrs, Stevens Point	G. E. MacKinnon, Prentice.
Price-Taylor	F. W. Mitchell, Medford	Susan Jones, Racine.
Racine	J. F. Bennett, Burlington	G. Benson, Richland Center.
Richland	Bertha Reynolds, Lone Rock	E. C. Hartman, Janesville.
Rock	H. E. Burger, Beloit	A. C. Edwards, Baraboo.
Sauk	A. L. Farnsworth, Baraboo	L. W. Peterson, Shawano.
Shawano	C. E. Stubenvoll, Shawano	A. C. Radloff, Plymouth.
Sheboygan	John Hansen, Glenbeulah	R. L. MacCornack, Whitehall.
Trempealeau-Jackson-Buffalo	J. W. Lowe, Merrillan	Wm. H. Remer, Chaseburg.
Vernon	W. M. Trowbridge, Viroqua	S. G. Meany, East Troy.
Walworth	E. J. Fucik, Williams Bay	P. M. Kauth, Slinger.
Washington-Ozaukee	N. E. Hausmann, Kewaskum	J. F. Wilkinson, Oconomowoc.
Waukesha	W. B. Campbell, Waukesha	F. J. Pfeifer, New London
Waupaca	R. K. Irvine, Manawa	M. C. Haines, Oshkosh.
Winnebago	G. V. Lynch, Oshkosh	W. G. Sexton, Marshfield.
Wood	F. X. Pomainville, Wisconsin Rapids	

SOCIETY PROCEEDINGS

ASHLAND–BAYFIELD–IRON

At a special meeting of the Ashland–Bayfield–Iron County Medical Society, the following resolution was adopted:

After a sojourn of seventy-six years between the eternity of the past and the eternity of the future, Dr. Adellon P. Andrus passed from this life to what he believed to be light of eternal day.

Dr. Andrus was born at Binghampton, New York, November 10, 1854, and died at Ashland, Wisconsin, February 22, 1931.

When a child his family moved to Amboy, Illinois, settling on a farm. At the age of 18 he drove to Humbird, Wisconsin, his father having preceded him there. He drove a team and spring wagon accompanied only by his dog and it took nearly three weeks to make the trip through primitive Wisconsin of that day camping out by the way and sleeping under the wagon at night.

For the most part he made his own way in the world, acquired a good education and graduated from Hahnemann Medical College, Chicago, in 1880. He returned to Fairchild and began the practice of his profession. He came to Ashland in 1888 where he bacame active in his practice and in the advancement of the community with which he had cast his lot.

He was an active energetic man and as a citizen was for some years a member of the city council and county board, later a member of the fire and police commission, always giving freely of his time, money and energy for the public welfare. Big hearted, kindly and friendly he ministered to those in distress and fulfilled the ideals of the family physician in real life.

For some years he was a member of the Wisconsin State Board of Medical Examiners. He practiced homeopathy though, like most of those of that school, drifted gradually into regular medicine and was admitted to membership in the Ashland, Bayfield, Iron County Medical Society in 1903 and kept up his membership until the time of his death.

He was an enthusiastic agriculturist and was an earily advocate of the redemption of cut over lands in northern Wisconsin. He established a dairy farm and built the first up to date dairy barn in this section to carry out his ideas of the importance of sanitary conditions which should surround a milk supply.

He was a lover of horses, cows and dogs and always advocated pedigreed stock. Something of an athlete he was a lover of clean manly sport.

Dr. Andrus was a devout Christian and one of the pillars of the Methodist Church, being active in the West Wisconsin Conference. His purse, his counsel and his professional skill were ever at the command of those sick or in trouble.

His activity had scarcely waned when death through angina pectoris overtook him in the full strength of years and accomplishment leaving a son, a daughter and a host of grateful friends to perpetuate the name and memory of a good man, a good citizen and a good physician.

WHEREAS, The Ashland, Bayfield, Iron County Medical Society has in the death of Dr. Adellon P. Andrus lost an honored member and

WHEREAS, The city of Ashland and a large part of northern Wisconsin has lost a valuable citizen and a conscientious medical advisor and

WHEREAS, In the loss of a father, friend and physician this Society shares with his relatives and the multitude of grateful friends who have been recipients of his service and generosity throughout the 51 years of his practice and in order that a record of his life and accomplishments may be preserved in the annals of this Society

Resolved, That this record and these resolutions be adopted and included in the minutes of this meeting and a copy be sent to the survivors of Dr. Andrus' family.

Signed,

M. L. YOUNG,
A. X. KAMM,
J. M. DODD.

BROWN-KEWAUNEE

The February meeting of the Brown-Kewaunee County Medical Society was held on February 19th, at the Y. M. C. A. banquet hall, Green Bay. About 40 members were present.

The dinner was held at 6:00 p. m. and after the dinner Dr. Arthur J. Cramp, director of the bureau of investigation of the American Medical Association, gave a highly instructive and interesting talk on "Patent medicine and the method in which the A. M. A. deals with matters of this kind." After Dr. Cramp's talk the business of the society was taken up.

Dr. Carter, chairman of the committee on by-laws, made a report of the progress of this committee. A few suggested changes in the method of procedure in conducting meetings were made, in order that the constitution and by-laws conform with the present growth and need of the society. It was agreed to have the present committee stand as appointed and continue their work.

Dr. Atkinson, chairman of the committee on public health, made a report on the proposed method of administration of toxin-antitoxin to the children of this city. The following plan was adopted. All children who wish, go to the health center and receive the treatment free, in the same manner as vaccination has been given. Any child who desires to go to the family physician may do

so and the toxin-antitoxin will be furnished the physician free by the health department.

Motion was made to adopt the Metropolitan Life Ins. Co., nurse's set of rules in caring for the sick.

The following resolutions were read and adopted.

1. Approving the State Hospital Bill 182A and urging the passage of same.
2. Recommending the defeat of the Anti-Vivisection Bill 178A.
3. Recommending the passage of Bill 71A, which purposes the free choice of physicians instead of the panel system.

A copy of these resolutions to be sent to members of the Wisconsin State Legislature.

The resolutions follow:

WHEREAS, We, the Brown-Kewaunee County Medical Society believe that vivisection is vitally essential to the advancement of medical science, and

WHEREAS, Many human lives can be saved by knowledge acquired in this matter.

Resolved, That the Brown-Kewaunee County Medical Society urge the defeat of the Anti-Vivisection bill (178A).

Be it further resolved, That a copy of this resolution be forwarded to the members of the Assembly and the President and Secretary of the Wisconsin State Medical Society.

A. J. MCCAREY, *President.*
EUGENE S. KNOX, *Secretary.*

WHEREAS, We, the Brown-Kewaunee County Medical Society, believe that the indigent county patients patients can frequently be treated in local hospitals and by local physicians efficiently and economically, and

WHEREAS, We feel that the best interest of the patient and the public will be served by the free exercise of that right.

Resolved, That the Brown-Kewaunee County Medical Society in meeting assembled heartily commend and urge the passage of Bill (71A) which proposes free choice of physicians instead of the panel system in the administration of the Workmen's Compensation Act.

Be it further resolved, That a copy of this resolution be forwarded to the members of the Assembly and the President and Secretary of the Wisconsin State Medical Society.

A. J. MCCAREY, *President.*
EUGENE S. KNOX, *Secretary.*

WHEREAS, We, the Brown-Kewaunee County Medical Society, believe that the indigent county patients can frequently be treated in local hospitals and by local physicians efficiently and economically, and

WHEREAS, Transportation to distant cities represents an additional expense to the county, and removal from friends and relatives is often a mental or physical hardship to the patient.

Resolved, That the Brown-Kewaunee County Medical Society indorse and urge the passage of the assembly bill (182A), which will authorize the county Judge to commit county indigent patients to local hospitals and local physicians, provided the patient's needs can be equally well met.

Be it further resolved, That a copy of this resolution be forwarded to the members of the Assembly and the President and Secretary of the Wisconsin State Medical Society.

A. J. MCCAREY, *President.*
EUGENE S. KNOX, *Secretary.*

COLUMBIA

At a meeting of the Columbia County Medical Society held at Portage, February 18th, a business session was held, subjects being discussed that were not finished at previous meetings.

A meeting to organize an auxiliary was held at the same time. Mrs. H. E. Gillette, Pardeeville, was elected President; Mrs. J. R. Kellogg, Portage, vice-president; Mrs. C. W. Henney, Portage, Secretary; Mrs. James MacGregor, Portage, treasurer.

H. E. G.

DANE

The March meeting of the Dane County Medical Society was held on Thursday, March 12th, at Madison General Hospital at eight o'clock.

Dr. Ernst A. Pohle, roentgenologist at Wisconsin General Hospital, Madison, discussed "The Present Status of Roentgen Deep Therapy in Malignant Disease."

Dr. Frank W. Mackoy, roentgenologist at Sacred Heart Sanitarium, Milwaukee, talked on "Roentgenology as a Diagnostic Aid in Gastro-Intestinal Diseases."

DODGE

The Dodge County Medical Society met at Horicon on February 26th at Community Hall.

Dr. Joseph W. Jackson, Madison, addressed the group on "The Value of Professional Organization as it is Related to the Medical Profession."

FOND DU LAC

A meeting of the Fond du Lac County Medical Society was held on March 11th at the Hotel Retlaw, Fond du Lac. Dr. Cleveland J. White of Northwestern University was the speaker of the evening, the subject of his address was "Skin Diseases."

The program followed a six-thirty o'clock dinner.

Dr. White conducted a clinic in the afternoon at St. Agnes Hospital.

GREEN LAKE—WAUSHARA—ADAMS

Dr. Phillips F. Greene, associate professor of surgery, University of Wisconsin, spoke on "Helps to Early Diagnosis of Cancer" at the regular monthly meeting of the Green Lake, Waushara–Adams County Medical Society held at the Hotel Whiting, Berlin, on March 13th.

The meeting was preceded by a six-thirty dinner after which the Woman's Auxiliary of the Society adjourned to the home of Mrs. B. E. Scott where a social meeting was held.

MARINETTE-FLORENCE

The Marinette-Florence County Medical Society held its regular monthly meeting Tuesday evening, February 24th.

Mr. B. E. Kuechle of the Employers Mutual Liability Insurance Company of Wausau gave an excellent address on "Insurance for the Doctor." It was an educational talk, explaining the different forms of risks, the proper forms for particulars, coverage, errors and misunderstandings explained.

All in all it was a very enjoyable evening. An excellent dinner was served at the hotel. M. D. B.

MILWAUKEE

The monthly meeting of The Medical Society of Milwaukee County was held at the Hotel Pfister on March 13, 1931. Meeting was called to order by President E. L. Tharinger at 8 P. M.

Following the reading of the minutes of the previous meeting the executive secretary made a brief report.

Communication was read from Dr. G. J. Kaumheimer expressing his appreciation of being made an honorary member of the Society.

The scientific program was then presented.

Dr. William J. Carson presented a paper on, "Intravenous Urography."

Dr. Carson's paper was discussed by Doctors J. E. Habbe and R. W. Benton.

Dr. O. H. Robertson, associate professor of medicine, Rush Medical College, University of Chicago, addressed the Society on, "The Treatment of Pneumonia."

Discussion was lead by Dr. F. D. Murphy, who was followed by Doctors L. M. Warfield, Joseph Lettenberger, A. L. Kastner, A. W Gray, M. M. Spitz, M. G. Peterman, Wm. J. Egan and Wm. M. Jermain.

The meeting then adjourned for the social hour. There were 190 present.

OUTAGAMIE

The Outagamie County Medical Society met at Hotel Northern, Appleton, on March 12th. Dr. Carl D. Neidhold, Appleton, and Dr. D. M. Gallaher, Appleton, discussed "Infant Feeding, Both Normal and Abnormal." A dinner preceded the program.

The following officers were elected for the year 1931 of the Outagamie County Medical Society: President, Dr. Joseph Benton, Appleton; Vice-president, Dr. Edward F. Mielke, Appleton; Secretary-Treasurer, Ralph V. Landis, Appleton.

POLK

The regular monthly meeting of the Polk County Medical Society was held on February 19 at Amery. Members of the Society were dinner guests of Dr. Wm. Cornwall.

The entire evening was devoted to the discussion of "The Contract System of Caring for the Indigent Sick." After a thorough discussion of the contract an individual vote was taken for the adoption of the contract. All members voted "yes".

The President and the Secretary were given authority to act as the Society's agent and meet with the Childrens Code Committee and sign the contract.

Members of the Polk County Society were dinner guests of Dr. J. A. Riegal at St. Croix Falls on March 20.

The first part of the program was devoted to the discussion of the recently adopted contract for caring of the indigent. This contract was explained in detail to the members of the Society cautioning the members to secure authorization for their county cases.

The remainder of the evening was devoted to the discussion of medical cases by Dr. H. C. Caldwell.

PORTAGE

A meeting of the Portage County Medical Society was held on February 26th at St. Michael's Hospital, Stevens Point. Dr. R. W. Rice, Stevens Point, read a paper on "The Estimation of Permanent Disabilities Following Trauma, or Injuries," and Dr. W. J. Bleckwenn, of the University of Wisconsin, presented a paper on "Encephalology in Head Injuries."

RACINE

The regular meeting of the Racine County Medical Society was held at the Racine Elks Club on Thursday evening, February 19th, at eight o'clock.

A moving picture film demonstrating common types of fractures was shown by Mr. Nelson, a representative of the Petrolagar Company.

Dr. Arnold S. Jackson, Madison, gave an interesting and profitable address on the subject of "Surgery of the Thyroid," illustrated by several x-ray plates.

Dr. Richard B. Stout, Madison, gave a fine talk on "Spinal Anesthesia" with illustrations.

Following the meeting, a luncheon was served.

Another meeting of the Racine County Medical Society was held at the Racine Elks Club on Thursday evening, March 19th, at eight o'clock. The following program was presented:

Report of the White House Conference by Dr. John Docter, Racine.

Some Phases of Eczema in Children by Dr. S. M. Markson, head of the department of Dermatology at Marquette University.

Present Status of Vitamines by Dr. M. G. Peterman, head of the department of Pediatrics at Marquette University.

ROCK

Both the Rock County Medical Society and the Woman's Auxiliary of the society presented interesting programs at their monthly meetings held in the Monterey hotel February 24th. Sixty doctors

attended the dinner meeting of the society and 18 were present for the auxiliary meeting.

Dr. Chester Kurtz, University of Wisconsin, gave a lecture on "Diseases of the Heart," in which he considered the subject from the standpoint of the general practitioner. Dr. William S. Middleton discussed new phases of pernicious anaemia. A group of readings by Mrs. Wayne A. Munn was one of the pleasing presentations on the program.

Dr. G. K. Wooll, president of the society, announced that Dr. Edward Ochsner, Chicago, has been secured as speaker for the meeting to be held in Beloit, March 31. Dr. Ochsner will discuss the status of state medicine.

Mrs. F. E. Brinkerhoff, Beloit, president of the auxiliary, presided at the meeting of this group. Dr. Wooll gave a talk on "State Medicine in Europe," in which he told how doctors in Denmark and Austria are in the employ of the state. The philanthropic committee, Mrs. Ralph Hartman, Janesville, and Mrs. T. F. Shinnick, Beloit, reported that the Beloit Federation clubs, as well as some of the Janesville clubs, are to provide from two to four entertainments at Pinehurst sanatorium for the next three months.

The auxiliary voted to present an evergreen tree to Pinehurst, which may be used as a Christmas tree. It was decided to approach the two Garden clubs of Janesville and Beloit for aid in receiving donations of shrubs, plants and seeds for beautifying Pinehurst grounds.

The March meeting will be held at the home of Dr. Jessie Allen, Beloit, who has invited the auxiliary to a 6:30 dinner. Dr. Allen founded the group.

WINNEBAGO

A meeting of the Winnebago County Medical Society was held at the home of Dr. F. C. Senn, 147 Waugoo street, Oshkosh, on February 20th. Prof. J. O. Frank of State Teachers College was speaker of the evening.

WOOD

At the annual meeting of the Wood County Medical Society held in the Hotel Witter at Wisconsin Rapids on February 17th, the following were elected to office: President, Dr. F. X. Pomainville, Wisconsin Rapids; Vice-President, Dr. K. H. Doege, Marshfield; Secretary, Dr. W. G. Sexton, Marshfield.

Speakers of the evening were Dr. K. H. Doege of Marshfield and Dr Nathan Goldberg, interne at St. Joseph's Hospital, Marshfield.

GREEN BAY ACADEMY OF MEDICINE

The regular meeting of the Green Bay Academy of Medicine was held on March 11th in St. Vincent's Hospital, Green Bay. Dr. R. C. Cantwell, Shawano, presented a paper on "Some Diseases of the Colon" with Drs. W. P. Tippet and L. D. Quigley, Green Bay, leading the discussion.

MILWAUKEE ACADEMY OF MEDICINE

A meeting of the Milwaukee Academy of Medicine was held on Tuesday, February 24th, at eight o'clock. Dr. M. H. Severs of the University of Wisconsin gave an address on "Physiology and Pharmacology of the Kidney" and Dr. Hans A. Jarre of Detroit presented "Roentgen Physiologic Studies of the Urinary Passages."

At the March 10th meeting of the Academy the following program was presented:

Report of Patient with Pick's Disease by Dr. F. W. Madison, Milwaukee.

Favorable Fractures of the Femoral Neck by Dr.W. P. Blount, Milwaukee.

The Status of Roentgenology in the Teaching of Medicine by Dr. F. J. Hodges, Madison.

MILWAUKEE HOSPITAL INTERNS' ASSOCIATION

At the first meeting of the Milwaukee Hospital Interns' Association for the year 1931, the following officers were elected: President, Dr. Edward O. Gertenbach; Vice-President, Dr. Edwin L. Everts; Secretary, Dr. Arthur C. Hansen; and Treasurer, Dr. Sylvester E. Coffey. Dr. Ralph P. Sproule was elected to represent the staff on the advisory board.

The next meeting will be held at the home of Dr. O. R. Lillie on Wednesday, April 15, 1931.

The Milwaukee Hospital Interns' Association is an organization whose membership is composed of past and present interns of the hospital.

The purpose of the organization is to cultivate a spirit of kindly social relationship between its members and to promote scientific study as an aid to increase professional efficiency.

The Milwaukee Hospital was first established in 1863 by the Institution of Protestant Deaconesses. In 1883 the old hospital was torn down and a new building erected in its stead. Later two modern wings were added 1912 and 1926 respectively. Recently the work of razing the last of the old structure was started. In its place will stand a new $350,000 addition.

The Milwaukee Hospital will be remembered as the scene of Dr. Nicholas Senn's early contributions to surgery. Dr. Senn was chief of staff until his removal to Chicago and his acceptance of the chair of surgery at Rush Medical College.

MILWAUKEE OTO-OPHTHALMIC

The regular monthly meeting of the Milwaukee Oto-Ophthalmic Society was held on March 17th at the Cudahy Tower. Dr. Frederick B. Balmer of Northwestern University, Chicago, addressed the Society on "The Otolaryngological Aspects of Electro-Surgery." Following Dr. Balmer's address, Dr. R. O. Ebert of Oshkosh presented a paper on, "Some Interesting and Instructive Cases."

MILWAUKEE ROENTGEN RAY

At the annual meeting of the Milwaukee Roentgen Ray Society held on February 6th at the Wisconsin Club, the following officers for the coming year were elected: President, Dr. C. A. H. Fortier; vice-president, Dr. A. R. Altenhofen; secretary-treasurer, Dr. J. E. Habbe. Plans were discussed for the State Radiological Section meeting to be held in Milwaukee the latter part of May.

UNIVERSITY OF WISCONSIN

Members of the University of Wisconsin Medical Society met on Wednesday, March 18th, to hear Professor George L. Clark of the University of Illinois present his illustrated lecture on "An Analysis of Tissue by X-Ray."

On Friday, March 20th, members of this Society heard Professor J. Whitridge Williams of Johns Hopkins Hospital, Baltimore, deliver an address on "The Third Stage of Labor and Thereafter."

NEWS ITEMS AND PERSONALS

Because of an attack of the "flu," Dr. A. W. Rogers of Oconomowoc, was unable to take a proposed trip to Mexico for which he had planned to leave on February 22nd.

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Dr. Spencer D. Beebe, councilor of the seventh district, returned on February 28th from a month's post-graduate work at Charity Hospital, New Orleans, where Dr. Beebe's son is interning. If present plans prevail, Dr. Beebe's son will become associated with the Sparta Clinic in July.

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Dr. G. B. McKnight of Fond du Lac spoke before a meeting of the Fond du Lac Woman's Club on the subject "The Health and Milk Situation in the City."

—△—

Dr. E. C. Cary of Reedsville was promoted to captain in the medical reserve corps. Appointment came on his birthday in February.

—△—

Dr and Mrs. William Snow Miller, Madison, returned early in March from several weeks' visit in the East. Dr. Miller attended the Child Health Conference in Washington, and in New Haven delivered the opening lecture under the Carmalt Foundation, before the Beaumont Club of Yale University.

—△—

Dr. Jessie P. Allen of Beloit talked on "Vivisection" before a meeting of the Graduate Nurses Club on March 6th.

—△—

Dr. and Mrs. H. A. Raube of Beloit returned on February 20th after a six months' sojourn in Europe, where Dr. Raube took post-graduate work at the University of Vienna, and in Paris, Munich and Berlin. They were in Vienna four and half months, where Dr. Raube studied surgery. The remainder of their stay was spent in touring Switzerland, Italy, and France.

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There were 3,308 deaths from cancer in Wisconsin last year, an increase of 108 over the previous year, according to a report of the State Board of Health.

Dr. W. E. Bannen of La Crosse was the principal speaker at the annual court of honor and pageant of Boy Scouts which was held at La Crosse on March first. Dr. Bannen spoke on "The Eagle Scout and Loyalty to Scouting."

—△—

Dr. W. W. Kelly, president of the Green Bay school board, spoke before a meeting of the Kiwanis club at the Northland Hotel, Green Bay. Dr. Kelly talked on the public school system.

—△—

Dr. G. E. Crosley, Janesville, read a paper on "Physiotherapy" at the monthly meeting of Mercy Hospital staff, Janesville. Dr. Richard W. Farnsworth was elected to membership at this meeting.

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Dr. M. D. Bird of Marinette returned early in March from a visit in St. Augustine, Florida.

—△—

Dr. R. G. Osterheld of Stoughton gave a talk on "Tuberculosis" before a meeting of the South Side Parent-Teachers Association.

—△—

Drs. L. M. and W. M. Smith who were licensed in Wisconsin in January 1931 have opened offices for the practice of general surgery medicine and diagnosis in the First National Bank building, Oshkosh.

—△—

Dr. B. J. Schwartz of Kenosha is recovering from an operation.

—△—

Childbirth cost the lives of 267 Wisconsin women in 1930, according to a report of the bureau of vital statistics of the State Board of Health. This is a decrease of 18 deaths over the year 1929.

—△—

Dr. Wm. B. Rydell, a graduate of Harvard Medical School in 1929, has joined the Rice Lake Clinic.

—△—

Dr. J. C. Elsom, Madison, delivered an address on "The Boy and His Dad" at a Fathers' and Sons' banquet commemorating the twenty-first birthday of the Boy Scout movement in the United States.

"The Cost of Medical Care" was the subject of an address by Dr. V. F. Marshall of Appleton before a noon-day meeting of the Rotary Club at Appleton.

—△—

"Maternal Hygiene and Infant Mortality" was the subject of an address by Dr. W. W. Bauer of Racine before a public meeting sponsored by the First Baptist Guild.

—△—

Dr. and Mrs. Joseph Dean, Madison, visited in Philadelphia at the home of their son, Dr. Joseph C. Dean.

—△—

Dr. Conrad Tasche and his son, Dr. Leslie W. Tasche, have formed partnership for private practice, in Sheboygan. They were formerly associated with the Sheboygan Clinic.

—△—

Dr. H. B. Wentz, formerly physician at the state prison, Waupun, has opened an office in Oakfield in the McKnight building. Because of his health, Dr. Wentz was forced to give up his work at the prison.

—△—

Dr. F. A. Davis, Madison, left on March 14th for Palm Beach, Florida, where he will remain for a month.

—△—

Doctors who will compose the medical staff of the Boy Scout summer camp at Tomahawk Island, are the following: Doctors George H. Conklin, H. A. Sincock, V. E. Ekblad, John Baird and E. E. Carpenter, all of Superior.

—△—

The new Community Hospital at New London was dedicated on Sunday, March 22nd, with a dinner at twelve noon followed by a dedication program and the laying of the cornerstone.

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Dr. F. A. Stratton of Milwaukee gave a talk on Goiter at the last meeting of the Staff of the Holy Family Hospital in Manitowoc.

MILWAUKEE

Dr. F. D. Murphy gave a talk on "Diabetes, Its Complications and Its Management," before the Private Duty Nurses' Section of the Fourth and Fifth Districts, Wisconsin State Nurses' Association, in February.

—△—

The Auditorium Committee of the Inter-State Post-graduate Medical Association met at the Mariner Tower on March 4th, to discuss plans for the forthcoming International Medical Assembly. Dr. H. J. Gramling is chairman of this committee. Members of the committee are: Doctors H. D. Sykes, H. E. Webb, Wm. Nelson and John O. Dieterle.

—△—

Dr. and Mrs. James M. Hyde of Brandon, Iowa, were guests of Mrs. George R. Lewis of Milwaukee last month.

Dr. and Mrs. Rock Sleyster left on February 25th for New York. They sailed February 27th on a Mediterranean Cruise.

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Dr. and Mrs. E. J. Purtell and Dr. and Mrs. T. A. Purtell left for a visit to New Orleans and other cities last month.

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Dr. and Mrs. Wm. J. Egan vacationed at Tucson, Arizona, the latter part of February.

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Dr. and Mrs. V. J. Taugher left February 24th on a three weeks' trip to Biloxi, Miss., and Galveston, Texas.

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The St. Monica Hospital Association composed of members of St. Monica's Church plan to erect a hospital in Whitefish Bay. Members of the church have already raised $40,000.00 by subscription. The hospital will have a capacity of 100 beds and the estimated cost is $250,000.00. Rev. Peter E. Dietz, pastor of St. Monica's Church, stated that the hospital is planned to meet the needs of a rapidly expanding community.

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Dr. Karl E. Kassowitz presented a paper on "The Diagnosis and Treatment of Pulmonary Abscess," at a staff meeting of Muirdale Hospital on March 3rd.

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Dr. and Mrs. G. A. Carhart left on March 5th for a cruise to Havana and Nausau.

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The engagement of Miss Ruth Dorothy Krome and Dr Robert I. Hiller was announced by Mr. and Mrs. Max Krome of M lwaukee on March 1st.

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Dr. Karl E. Kassowitz gave a report on the White House Conference on Child Health and Protection at the monthly meeting of the staff of Milwaukee Children's Hospital on February 26th. Dr. Kassowitz attended the White House Conference upon the invitation of the Secretary of the Interior.

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The first minute book of The Medical Society of Milwaukee County which was found in the attic of the late Dr. Daniel Hopkinson was turned over to the Society by Dr. E. L. Tharinger in February. The first meeting of the Society, May 5, 1846, is recorded in this book. The officers were: Dr. E. S. Marsh, president; Dr. A. G. Castlemann, vice-president; Dr. J. K. Bartlett, secretary, and Dr. Selby, treasurer.

Many interesting side lights on the practice of medicine in territorial days are revealed by these minutes, which will be carefully preserved.

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The following speakers appeared for the Speakers' Bureau of The Medical Society of Milwaukee County during February: Dr. L. M. Warfield spoke before the Civitan Club on "What You Should Know About Your Heart," and also before the Twentieth Century Club and the Hopkins

Street School P. T. A. on the same subject. Dr. Herbert W. Powers addressed the P. T. A. of St. John's School, and the P. T. A. of the Lee Street School on "Character Formation in the Child."

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Dr. and Mrs. A. W. Gray returned from a three weeks' motor trip to Florida the latter part of February.

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Dr. Eben J. Carey of Marquette University spoke on "The Pope and Medical Science," before the monthly meeting of the Holy Name Society of St. Frederick's Church in Cudahy on March 6th.

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A complete survey of vital statistics, health promotion work and agencies for promoting clean living in Milwaukee was concluded on March 1st. The Medical Society of Milwaukee County participated actively in this survey.

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Dr. R. P. Sproule, former president of The Medical Society of Milwaukee County, gave a dinner at his home on March 7th, for the past presidents and the present officers of the Society. Those present were: Doctors Gilbert E. Seaman, P. M. Currer, W. H. Washburn, G. J. Kaumheimer, J. J. McGovern, Charles Fidler, G. H. Fellman, A. J. Patek, H. J. Gramling, Frederick Stratton, W. F. Grotjan, S. J. Seeger, Charles H. Stoddard, R. G. Sayle and Mr. Theodore Wiprud.

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Plans for a new nurses' home to be built near the New County Hospital are to be submitted to the board of trustees of county institutions, it was announced by W. L. Coffey. The plans provide for a $500,000.00 home with accommodations for 267 nurses. The building is to be H-shaped, five stories high with large lecture room, three class rooms, chemistry and bacteriology laboratory, class demonstration room and a supply room. A gymnasium will be in the basement. The south wing of the first and second floors will be living quarters for graduate nurses and school department heads.

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The first session of the Practical Postgraduate Course in Diagnosis of Chest Diseases sponsored by the Medical Society of Milwaukee County was held at the Milwaukee Academy of Medicine on March 9th at 8 p. m. Over 50 were present and enrolled for the course. Dr. J. A. Myers of Minneapolis was the first lecturer and spoke on, "The Diagnosis of Tuberculosis in Children."

Those enrolled were divided into small groups and will take clinical instruction under the following physicians in Milwaukee specializing in chest diseases: Doctors A. L. Banyai, G. Bellis, G. R. Ernst, T. L. Harrington, Charles Ide, Karl E. Kassowitz, Oscar Lotz, F. D. Murphy, A. A. Pleyte, J. Schlikowski, T. L. Squier, and L. M. Warfield.

Those enrolled for this course are:

Dr. M. C. Borman	Dr. George W. Neilson
Dr. P. G. Frey	Dr. Maurice Olsen
Dr. A. H. Hermann	Dr. Theodore Rolfs
Dr. C. H. Baumgart	Dr. S. Spilberg
Dr. W. P. Glisch	Dr. J. F. Haug
Dr. D. F. Pierce	Dr. C. J. Becker
Dr. J. R. Dundon	Dr. H. S. Smith
Dr. E. L. Belknap	Dr. B. Krueger
Dr. J. B. Ozonoff	Dr. H. O. Zurheide
Dr. Edward Jackson	Dr. U. A. Schlueter
Dr. Maurice B. Byrnes	Dr. W. F. Ragan
Dr. A. L. Suhr	Dr. R. H. Frederich
Dr. Edwin B. Gute	Dr. C. C. Reinke
Dr. George Light	Dr. E. T. Harrington
Dr. H. B. Miner	Dr. P. C. Wagner
Dr. R. A. Gilfry	Dr. G. F. Mueller
Dr. E. H. Rogers	Dr. L. P. Stamm
Dr. P. L. Callan	Dr. R. C. Schodron
Dr. W. F. Grotjan	Dr. P. J. Niland
Dr. H. P. Robinson	Dr. J. J. McGovern
Dr. G. A. Kriz	Dr. P. J. Eisenberg
Dr. S. H. Wolter	Dr. James G. Curtin
Dr. S. G. Higgins	Dr. Millard Tufts
Dr. T. S. Lawler	Dr. Henry Gramling
Dr. Joseph Gramling	Dr. W. L. Stranberg

Ten sessions will be held in all. Three of these will be devoted to general sessions when all members will be present. Dr. W. S. Middleton of Madison has been secured for the meeting to be held on April 6th. There will be seven clinical sessions.

So far as it is known, this course is unique and is the first of its kind sponsored by a medical society. The course was inaugurated under the supervision of a special committee of which Dr. C. H. Stoddard is chairman. Other members of the committee are: Doctors Charles Ide, Hoyt E. Dearholt, W. F. Grotjan and Theodore Rolfs. Dr. T. L. Squier is chairman of the group of instructors and will direct their activities.

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Mr. Paul Benjamin, executive secretary of the committee on the costs of medical care, spoke at the Milwaukee Academy of Medicine on March 2nd. Mr. Benjamin appeared under the auspices of the Central Council of Social Agencies.

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The social medicine and medical economics committee of The Medical Society of Milwaukee County met with Mr. W. L. Coffey, Manager of County Institutions, to discuss with him the recent survey made of the County and Emergency Hospital and of the Milwaukee County Dispensary.

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Dr. and Mrs. Stanley J. Seeger and family left for San Antonio, Texas, on March 10th, for a three weeks' stay.

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Dr. E. L. Miloslavich, director of the department of clinical pathology and medical research at St. Mary's Hospital, Milwaukee, addressed the Annual Meeting of the District Attorneys of the State of

Wisconsin, on January 27, in Milwaukee, on "Criminological Analysis of Recent Murder Cases." He discussed the medico-legal and criminological aspects. Dr. Miloslavich was elected an Honorary Member of the Wisconsin District Attorneys' Association.

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Dr. and Mrs. E. L. Tharinger, Dr. and Mrs. T. J. Howard, and Dr. and Mrs. L. P. Stamm left on March 14, for a two weeks' vacation in Florida.

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Dr. Francis D. Murphy, medical director of the Milwaukee County Hospital and professor of internal medicine of Marquette University spoke at the annual mid-winter clinic of the Milwaukee County Dental Society on March 18. Dr. Murphy discussed, "Diseases of the Heart." Members of the Medical Society of Milwaukee County were invited.

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Dr. and Mrs. A. B. Vajda who have been sojourning in Washington returned to Milwaukee early in March.

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Dr. L. P. Tully presented a paper on, "The Coexistence of Syphilis and Tuberculosis," at the staff meeting of Muirdale Sanatorium on March 17.

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Dr. F. D. Murphy, professor of internal medicine, Marquette University, gave a series of radio talks over the Wisconsin News Station WISN during March. The schedule was as follows:

March 4. "How to Prevent Diabetes."
March 11. "The Complications of Diabetes Mellitus."
March 18. "The Treatment of Diabetes Mellitus."
March 21. "What Every One Should Know About Diabetes."

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The Visiting Nurse Association cared for more patients during February than during any previous month in its history, Miss Erna Kowalke reported to the Community Fund, on March 18. Almost a third of the 11,000 visits made by the nurses during the month were influenza and pneumonia cases and over 2000 more visits were made than in February, 1930. An increase in requests for maternity service was also noted, and the nurses were called to assist physicians in 129 births in private homes.

Hourly nursing service, the newest development in nursing care, was also in demand and 100 visits and treatments were given to patients by appointment.

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The Goodfellow House, a home for homeless and unemployed men sponsored by the Milwaukee Journal, is still in operation. The following medical men, members of The Medical Society of Milwaukee County, gave their services during March: Doctors Wm. J. Voellings, W. P. O'Malley, Edward Jackson, Emmett Cook, John Freedman, Edward Gertenbach, M. B. Byrnes, Charles V. Lynch, P. Perlson, Weber Hermann, Howard Hansen, F. J. Stirn, J. A. Jenner, Fred Selle, Paul J. Niland, John McCabe, R. E. Olson, A. J. Ruppenthal, R. A. Teschan, Wilmot P. Miller, and Alfred Suhr.

Sanitary inspection is made regularly by the Wisconsin National Guard Medical Unit under Major Wm. McKillip.

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The health department advisory committee of The Medical Society of Milwaukee County met at the executive secretary's office on March 19. Dr. John P. Koehler, Commissioner of Health, was present and problems of the Health Department relating to the medical professon were discussed.

The child welfare and public nursing committee of the Medical Society of Milwaukee County met at the executive offices on March 17, to consider the revision of the standing orders of the Visiting Nurse Association. Recommendations were made to the Association with the request that the revised orders be submitted again for approval.

ENGAGEMENTS

Dr. Robert I. Hiller, Milwaukee, to Miss Ruth Dorothy Krome, also of Milwaukee.

DEATHS

Dr. Irving David Wiltrout, Chippewa Falls, died at his home on February 28th from heart disease. Although he had been ill for the past six months, he still continued his official duties, as deputy state health officer of the Fourth District of this state, which office he held for the past four years.

Dr. Wiltrout was born at Schuylkill Haven, Pa., October 25, 1855. He was a graduate of Jefferson Medical College of Philadelphia in 1878. Until 1882 he was superintendent and physician in charge of the Schuylkill County Hospital and then moved to Hudson, Wisconsin, where he practiced for a number of years. He served as mayor of Hudson for three terms and built the Oliver Wendell Holmes hospital, now the Hudson Sanatorium, in 1887. He remained in this work until 1893, when he moved to Eau Claire, coming in 1913 to Chippewa Falls where he has since resided.

The deceased was a member of the Chippewa County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his widow, three sons and one daughter.

Dr. A. P. Andrus, Ashland, died on February 22nd, but a few minutes after he was taken to the hospital suffering from an acute heart attack.

Dr. Andrus was born in Binghamton, New York, in 1854. He attended the Hahnemann Medical College, graduating in 1880, and later took postgraduate work at Rush Medical College. He practiced first at Fairchild, Wisconsin, and then moved to Ashland in 1888.

He had been associated with the Dodd Clinic, Ashland, since it was started in 1920. For eight years he served as President of the State Board of Medical Examiners, and during the World war was a member of the Medical Advisory Board for the Ashland district.

Besides many other activities, he was a member of Ashland-Bayfield-Iron County Medical Society, the State Medical Society and the American Medical Association.

He is survived by one son, Dr. Dell Andrus of Ashland, and one daughter.

Dr. C. G. Dwight, formerly of Madison, died on March 6th at his home in Glendale, California, after a long illness.

Dr. Dwight was born in Plainwell, Michigan, in 1870. He was a graduate of Hahnemann Medical College Chicago, in 1897 and did post-graduate work in eye, ear, nose and throat diseases in New York, London and Vienna. Dr. Dwight came to Madison in 1912, and in 1914 joined Dr. F. A. Davis in forming the Dwight and Davis Clinic. He retired in 1926 because of ill health and with his family moved to Glendale, California.

The deceased was a member of Dane County Medical Society, the State Medical Society and the American Medical Association. He was also a member of the American College of Surgeons.

He is survived by his widow, one son and three daughters.

Dr. G. B. Johnston, Abbotsford, died on February 20th at his home, of pneumonia and complications.

Dr. Johnston was born in Waterdown, Ontario, on February 10, 1863. He graduated from the University of Michigan School of Medicine in 1887 and started the practice of medicine in Iron Mountain, Michigan. From Michigan, he moved to Seymour, Wisconsin, and then to Athens, practicing in both towns before locating in Abbotsford in August, 1895.

He was a member of Clark County Medical Society, the State Medical Society and the American Medical Association.

He is survived by his widow, one son and one daughter.

Dr. Nellie Wentworth Cargill, Milwaukee, died on March 13th in Chicago. She had been in ill health for several months and had gone to Chicago for treatment.

Dr. Cargill was born in Syracuse, New York, in 1863. When she was 15, Dr. Cargill went to Chicago with her parents. She attended the Chicago high schools and later Northwestern University Medical School, graduating in 1893. For two years after serving internship, she was a member of the staff of Wesley Hospital in Chicago. She also served on the staff of the Wisconsin Industrial School for Girls, Milwaukee, for many years.

Dr. Cargill was a member of the Medical Society of Milwaukee County, the State Medical Society and the American Medical Association.

Dr. E. J. Purtell, Milwaukee, died on March 13th of heart disease after an illness of one week.

Dr. Purtell was born in 1863 and was a graduate of Rush Medical College in 1891. He was a member of Marquette University medical department and served for many years on the staff of Trinity Hospital. Early in his career he was Milwaukee county physician.

The deceased was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association. He was also a member of the Milwaukee Academy of Medicine and the Tri-State Medical Society.

He is survived by his widow, three sons and three daughters.

Dr. Gerald K. Wooll, Janesville, president of the Rock County Medical Society, died on March 16th in Mercy Hospital, Janesville. Taken suddenly ill with a heart attack while in Chicago the previous week, he returned to Janesville and entered the hospital for treatment where he died following a second and a third attack.

Dr. Wooll was born in Detroit, Michigan, in 1893, and came to Janesville with his parents when a child. He finished the pre-medical years at the University of Wisconsin, and was a graduate of Rush Medical College in 1920. For the past twelve years he had been a member of the Pember-Nuzum Clinic in Janesville, specializing in urology. He was a member of the state and national urological societies.

He was a member and former secretary of the Rock County Medical Society, member of the State Medical Society, and the American Medical Association. He was also a member of Chi Phi, Sigma Sigma, Phi Rho Sigma, Kiwanis, American Legion, and a Mason.

He is survived by his parents, and one sister, Mrs. J. G. Crownhart, Madison.

SOCIETY RECORDS

New Members

C. C. Atherton, Union Grove, Wis.

H. G. Brehm, 1658 N. Main St., Racine.

Charlotte Calvert, 38 Breese Terrace, Madison.

E. A. Titel, Greenleaf.

James S. Hess, Mauston.

W. L. Seng, 4001 Downer Ave., Milwaukee.

Arne C. Gorder, 324 E. Wisconsin Ave., Milwaukee.

H. R. Fehland, Wausau.

Frank A. Gruesen, 99 S. Main St., Ft. Atkinson.

T. H. Nammacher, Oconomowoc.

E. F. Freymiller, Boscobel.

Harry Shapiro, Friendship.

S. M. Turkeltaub, 238 Wisconsin Ave., Milwaukee.

Harold E. Cook, 530 Wisconsin Ave., Milwaukee.

Frank E. Darling, Jr., 619 Lincoln Ave., Milwaukee.

John Grill, 638—4th St., Milwaukee.

Wm. H. Studley, 2316 E. Edgewood Ave., Milwaukee.

Xavier Corso, Beaver Dam.

Changes in Address

Francis Paul, Waupun to Normandale, Madison, Wis.

M. R. French, Milwaukee to N. Y. Dept. of Health, Albany.

B. S. Rathert, St. Nazianz to Hilbert.

Resignations

A. J. Puls, Milwaukee.
Annette M. McIntire, New York City.
Walter J. Kelly, Alhambra, Calif.
V. A. Chapman, Milwaukee.
Mary L. Fitzpatrick, Milwaukee.
F. F. Fowle, Wauwatosa.
John H. Frank, Milwaukee.
Bertha T. Haessler, Milwaukee.
Hugo F. Mehl, Milwaukee.
S. C. McCorkle, Milwaukee.
E. J. Stone, West Allis.
R. J. Wenker, Chicago.
John F. Gates, Wauwatosa.
C. H. Erdman, Stanley.

Deaths from influenza in Wisconsin last year numbered but 470, as compared with 1,251 in 1929, according to the Bureau of Vital Statistics, State Board of Health.

Prevalence of the disease, which has assumed epidemic proportions in many eastern states, is increasing in Wisconsin, 143 cases having been reported for the week ending February 7, as compared with 111 state cases for the preceding week.

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Childbirth cost the deaths of only 267 Wisconsin women in 1930, according to the provisional report of the bureau of vital statistics, to mark a substantial decrease from the 1929 toll, by which Wisconsin ranked third among the states in point of fewest deaths from this cause. Department of commerce tabulations for 1929 showed 285 puerperal deaths for Wisconsin, marking a death rate of 5.1 and placing Wisconsin below only Minnesota and Utah for national honors. According to the provisional report, Wisconsin's maternal mortality rate now stands at 4.8 deaths per thousand live births, the lowest rate since 1919.

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Of the 585,103 Wisconsin births registered during the decade ending with the close of 1929, the boys outnumbered the girls by 16,943.

It has long been noted by statisticians, however, that infant mortality takes heavier toll of boys than girls, and the Wisconsin statistics for the past six years shows that deaths of boys under one year of age outnumbered those of girl infants by an average of 515 a year.

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Enforced use of paper table utensils in temporary eating places that lack running hot water is used by Walter G. Mase, director of the hotel and restaurant division, State Board of Health, in his annual report.

The proposed regulation is aimed at improving sanitary conditions at fairs throughout the state. The records of the bureau show that 751 temporary eating places at fairs were granted licenses in 1930. More than 1,000 inspections of these concerns were made, resulting in the request for higher sanitary requirements by the bureau.

* * *

A total of 15 cases of tularemia were reported in Wisconsin in 1930, as compared with but five cases in 1929, according to the Bureau of Communicable Diseases, State Board of Health.

The rabbit hunting season, which closed Dec. 31 throughout the state with the exception of Crawford county, was marked by eight cases of the disease in November and December, and six of these cases were contracted in the belt lying between Madison and the Illinois line.

* * *

Only three of the 37 accredited schools of nursing in Wisconsin have yet to inaugurate the prerequisite of a high school education, it is announced by Miss Adda Eldredge, director of the Bureau of Nursing Education, State Board of Health.

This increase of standards in the nursing profession of the state has developed since 1921, when only one Wisconsin nursing school lived up to a requirement that its students had completed a high school course or its equivalent before enrolling.

Therapeutic Notes

NEW AND NONOFFICIAL REMEDIES

In addition to the articles enumerated previously, the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Health Products Corporation:
Marine Liver Extract (White).

Schering Corporation:
Iopax.

The following articles have been exempted and included with the List of Exempted Medicinal Articles (New and Nonofficial Remedies, 1930, p. 477):

Chas. Pfizer & Co.:
Cinchophen-Pfizer.

G. D. Searle & Co.:
Ampules Sodium Thiosulphate (Searle) 5cc. +
Ampules Sodium Thiosulphate (Searle) 10cc. +

Postgraduate Extension Course in Insulin and Its Use to Visit Six Wisconsin Centers May 18-23

The use of insulin must command a larger place in the general practice of medicine if this great scientific discovery is to yield maximum rewards in prolonging the lives of diabetics. With this in mind, the University Extension one-day course in insulin and its use, mentioned in The Journal last month, is commended to physicians of the state who desire a better acquaintance with this remedial agent and its technique. It is especially recommended to those practitioners who attended medical school before the discovery of insulin; for such physicians, acquaintance with the subject has necessarily been limited.

The instructional staff includes the following:

Leland S. McKittrick, M. D., Boston, Mass.

Russell M. Wilder, M. D., University of Chicago.

E. L. Sevringhaus, M. D., University of Wisconsin.

Lenore L. Healey, dietitian, University of Wisconsin.

The sponsors of this course are the State Medical Society of Wisconsin, the University of Wisconsin Medical School, and the University Extension Division. The joint committee consists of Dr. Otho A. Fiedler, Sheboygan, Dr. G. Gundersen, La Crosse, Dr. J. F. Wilkinson, Oconomowoc, and Mr. J. G. Crownhart, for the Medical Society; Dean C. R. Bardeen, Dr. R. C. Buerki, Dr. J. S. Evans, and Dr. E. L. Sevringhaus, for the Medical School; and Dean Chester D. Snell, Chester Allen, and Nelson D. Connors, for the University Extension Division.

The instruction combines an afternoon of lectures and demonstrations for physicians, and a free evening lecture for the lay public.

A POSTGRADUATE COURSE NEAR HOME

The course is intended to be an inexpensive substitute for a postgraduate course at a metropolitan clinic. In providing for a public evening lecture without cost, in each city, it was thought that, in view of the large number of diabetics who are cared for in the home, there is value in teaching to laymen the necessity of continuous care of these cases under rigid rules prescribed by the family physician. Dr. Sevringhaus' evening lecture for the lay public will stress the avoidance of those diets and fat-reducing methods that have no sound scientific basis.

SCHEDULE FOR PHYSICIANS

1:00 p. m.

Madison, Wisconsin General Hospital, Monday ---------- May 18
Milwaukee, University Extension Center, 623 West State Street, Tuesday ---------- May 19
Oshkosh, Mercy Hospital, Wednesday, May 20
Wausau, Wausau Hotel, Thursday, May 21
Eau Claire, Sacred Heart Hospital, Friday ---------- May 22
La Crosse, Stoddard Hotel, 4th & State, Saturday ---------- May 23

FREE PUBLIC LECTURES

7:30 p. m.

Subject, "Diets, Diabetics, and Fat-Reducing Fads," by Dr. E. L. Sevringhaus
Madison, Room 230, Memorial Institute Building, North Charter Street ---------- May 18
Milwaukee, Lecture Hall, Public Museum, entrance on North 8th Street ---------- May 19
Oshkosh, Vocational School ---------- May 20
Wausau, Central High School (auspices of Wausau Vocational School) May 21
Eau Claire, High School ---------- May 22
La Crosse, Washburn School ---------- May 23

INSULIN'S REAL PURPOSE

The discovery of insulin in 1921 by Dr. Frederick Grant Banting and Dr. Charles H. Best, of Toronto, was followed within sixteen months by the use of insulin in medical colleges, hospitals, and clinics in this and other countries. The product has been standardized and its manufacture authorized by established supply houses. In this course insulin is advocated not as a cure for diabetes, which it is not, but for its real function of prolonging, with unimpaired efficiency, the lives of diabetic patients who receive proper care.

Dr. E. L. Sevringhaus
Madison

Dr. Russell M. Wilder
Chicago

Dr. L. S. McKittrick
Boston

It is significant that in Wisconsin, as elsewhere, the use of insulin and the careful regulation of the diet in individual cases are combining to lower the diabetic death rate. In the period since the discovery and use of insulin, according to the records of the State Board of Health, a material saving in life has taken place in this state among diabetic patients in all age groups up to 40 years. It is evident that a similar saving would be shown in the older age groups were these patients to follow more carefully the instructions for the regulation of diet and the use of insulin.

A book of instructions for physicians and patients will be given to each physician attending these one-day clinics. It will be found invaluable especially in acquainting the patient with his duties in maintaining the prescribed standards of diet and rules of living. Every item of home equipment and materials for urine testing necessary in the treatment of diabetes will be demonstrated.

In selecting the instructional staff, the sponsors of this course were careful to obtain lecturers who are not only outstanding specialists, by virtue of long research and hospital experience, but lecturers who have devoted years to teaching general practitioners how to use the technique of insulin administration as developed during the last decade.

THE CLINICAL PROGRAM

1:00 p. m.

Does the Patient Need Insulin?
When is Surgery Safe?
Diabetic Children.
Which Diet?
Questions and Informal Discussion.
Blood and Urine Tests. Demonstrations.
Management of Coma.
Gangrene, Osteomyelitis, and Amputations.
How Much Can Patients Be Taught?
Prepared Foods and Special Recipes.
Liquid Diets for Emergencies.
Care of the Feet.
Insulin Injection.
Planning and Serving Meals. Demonstrations.

OBSTETRICS COURSE IN SUMMER

In addition to the course in insulin, a 12-week course in Obstetrics and Gynecology will be held, beginning the middle of June, at Appleton, Green Bay, Manitowoc, Marinette, Oshkosh, and Sheboygan. Watch for details.

THE MEDICAL STAFF

Dr. McKittrick specializes in diabetic surgery at the New England Deaconess Hospital, where he works in association with Dr. E. P. Joslin, a national authority on diabetes. He will present the surgical problems in diabetes at each session. Dr. McKittrick, son of the late Dr. McKittrick of Eau Claire, is a native of Thorp, Wisconsin, and attended school at Eau Claire. He is a graduate of the University of Wisconsin, 1915, and of Harvard Medical School, 1918. He is visiting surgeon at Palmer Memorial Hospital (cancer), assistant surgeon at Massachusetts General Hospital, and assist-

ant surgeon at New England Deaconess Hospital. With Dr. H. F. Root, he is the author of "Diabetic Surgery" (1928), the only modern book on the subject.

Dr. Wilder will discuss psychological and medical problems in diabetes, with emphasis upon the importance of diet regulation. He will also discuss accepted procedures for the successful handling of children. Dr. Wilder was educated at the University of Chicago and Rush Medical College. He has done extensive research work in typhus fever as well as diabetes. On October 1, 1919, he became associate in a section of the Division of Medicine of the Mayo Clinic, in charge of the management of all diabetic cases, and later became the head of a section in that division, and professor of medicine in the Mayo Foundation, Graduate School of the University of Minnesota. Since May 1, 1929, he has been professor of medicine and chairman of the Department of Medicine, University of Chicago.

Dr. Sevringhaus, whose work in diabetes at the University of Wisconsin is well known to the profession in the state, will point out how the physician can recognize upon his first visit whether the patient is in danger of immediate coma, and, if so, how to handle the situation, and how he can tell whether or not the patient will need insulin. The use of emergency diets and the management of insulin shock will be stressed. Dr. Sevringhaus is a graduate of the University of Wisconsin and of Harvard Medical School. He has been associate professor of medicine at the University of Wisconsin and consultant in clinical chemistry at the Wisconsin Psychiatric Institute since 1927.

Miss Healy will instruct in the few special recipes necessary for satisfactory diets, devoting most of her time to showing how the patient can be trained to weigh and measure all the food with a minimum of trouble. Economy in the selection of food will have attention.

HOW TO REGISTER

The fee for the clinical course for physicians, including the book on the care of diabetic cases, is $5.00. Application may be made to the University Extension Division, 314 Extension Building, Madison, or to the nearest Extension field representative. These representatives are:

Appleton, M. C. Graff or E. M. Gorrow, 300 E. College Avenue, tel. 338.

Eau Claire, O. L. Krasselt, 1316 Woodland Avenue, tel. 2476W.

La Crosse, B. W. Meyer, 215 South 19th Street, tel. 1888M.

Madison, George A. Tyler, 315 University Extension Building, tel. Univ. 30W.

Milwaukee, N. D. Conners, 623 West State Street, tel. Marquette 7051.

Oshkosh, W. H. H. Liesch, 128 Central Avenue, tel. 2900.

New Policies Announced for Marquette University School of Medicine

Adoption of three new policies for the school of medicine, Marquette University, were announced in March by Dr. B. F. McGrath, dean of the school. Under the new policies, the subject system will replace the class system, orientation conferences are introduced for freshmen and sophomores, and a larger provision has been made for laboratory preparation in the main clinical subjects. The official announcement follows:

SUBJECT SYSTEM

In 1931–1932 the subject system replaces the class system. As commonly known, the former is in general the system abroad and also in a few of the schools of the United States. The decision in favor of the subject system is based on a familiar observation, namely, the mental differences between the two extremes of a class. In a word, while one student, grasping quickly, is able to cover the ground in the regular time, another student, perhaps equally able if not indeed a better prospect, may require at least another year. Again, there is the student of promise who needs to work his way. He deserves to be encouraged, but should not expect, nor should he be permitted to try to complete the medical course in the regular time. Another phase of the decision con-

cerns the incompetent: A part-time student manifesting mediocre ability should ipso facto be eliminated.

ORIENTATION CONFERENCES

Orientation conferences for freshmen and sophomores were introduced in the second semester of 1930–1931. These sessions are attended also by the faculty of the basic sciences. The directors are assigned from the clinical faculty. General plan: Definition of the subject, for example, "internal medicine"; listing of the principal conditions under the subject, with brief discussions; stressing the relationship between the subject and the basic sciences; special applications of the basic sciences to the subject. In some conferences the work is supplemented by lantern slides and motion pictures.

Schedule, second semester, Thursdays, 4:00 to 5:00:

1. February 19, PUBLIC HEALTH, Professor Koehler; 2. February 26, PREVENTIVE MEDICINE, Professor Squier; 3. March 5, ORAL MEDICINE AND SURGERY, Professor Federspiel; 4. March 12, PEDIATRICS, Professor Peterman; 5. March 19, OBSTETRICS AND GYNECOLOGY, Professor Davis; 6. March 26, INTERNAL MEDICINE, Professor Murphy; 7. April 9, GENERAL SURGERY, Professor Stratton; 8. April 16, NEUROLOGY, Professor H. Powers; 9. April 23, ORTHOPEDIC SURGERY, Professor J. Powers; 10. April 30, OPHTHALMOLOGY, Professor Heeb; 11. May 7, UROLOGY, Professor Sargent; 12. May 14, OTOLOGY, RHINOLOGY, LARYNGOLOGY, Professor Coffey; 13. May 21, MENTAL MEDICINE, Professor Roberts.

MEDICAL LABORATORIES

Marquette's surgical laboratories, organized in 1916, have been developed to an effective educative unit. Included in both third and fourth years, the work, briefly stated, consists of study and experience in the application of the principles of surgery as a foundation for the superstructure of clinical surgery. In a word, embodied in these laboratories are the following functions: the basic sciences applied, the fundamental and regional diseases of surgery, bandaging, splinting, and the principles of operative surgery. In the new policy the total time formerly allotted to the surgical laboratories is now divided between them and the medical laboratories. Similarly to the functions of the surgical laboratories, the medical laboratories are concerned with laying the foundation for the superstructure of clinical medicine. Thus provision has been made for laboratory preparation for the two main clinical subjects, namely, medicine and surgery. Work of medical laboratories: Clinical anatomy, physiology, chemistry, pathology and bacteriology; physical examinations, with the students themselves the subjects; x-ray studies, electrocardiograph; other experiences: blood pressure; blood circulation—diagnostic and therapeutic methods; lumbar and cisternal punctures; paracentesis of various cavities; the ordinary ophthalmic, nasal, aural, and oral examinations; other diagnostic tests and therapeutic procedures peculiar to medicine, which from time to time may be suggested by that department. Research is encouraged.

Arguments of Laymen Presented to Legislature Against Anti-Vivisection Measure; Assembly Kills Bill 86 to 1

Killing the so-called dog exemption anti-vivisection bill by a record vote of 86 to 1, the Wisconsin Assembly late in February gave the Wisconsin Anti-Vivisection Society its stern rebuke to the plea that animal experimentation in the interest of the advancement of medical science be abolished. Preceding the general vote in the Assembly, the Committee on Public Welfare reported the bill for killing by a unanimous vote after hearing arguments on the measure for upwards of two hours.

While those appearing against the bill included distinguished scientists of the Uni-

versity of Marquette and Wisconsin, the arguments advanced by three laymen are thought to be of particular interest to the readers of this Journal. The complete texts of the statements of Mr. J. G. Crownhart, Secretary of the State Medical Society of Wisconsin; Judge A. C. Backus, Milwaukee, Regent of the Universities of Marquette and Wisconsin, and Mr. Walter Corrigan, Senior, of Milwaukee, are accordingly printed by special request. Mr. Crownhart opened the hearing for those opposed to the bill.

Mr. J. G. Crownhart: As I have sat here listening to the remarks of the proponents of this measure, I have reflected on how prone we all are to question the sincerity of those who present radically different views than our own. So do I desire to preface my remarks to this committee by assuring you that neither I nor those who will follow me wish, by thought or word, to question the sincerity of purpose of those who advocate this measure.

Some of those who appeared before you this afternoon do not believe that some diseases are transmittable by germs. Some have stated in the printed word as well as speech that they believe vaccination for smallpox is a means for swelling the doctor's purse rather than protection against smallpox. Others have said that toxin-antitoxin saves no child from diphtheria. I cite this not to point out their errors here, but as proof of their sincerity. Obviously if they believe basically that such diseases are not spread by germs, then it follows that any experiments of whatever nature that have anything to do with germs are useless in the minds of the proponents of this measure.

Their argument for the adoption of the bill is twofold: first, that it cannot be shown that human beings have benefited by experimentation upon animals, and second, that such experiments as have been and are conducted, are conducted with cruelty and torture.

I wish to dwell upon the charge of cruelty for just a moment. My old home was Superior. Mrs. Charbonneau will recall that at the time of my boyhood the streets were of that peculiarly sticky red Lake Superior mud that made them frequently impassable in prolonged wet weather. Our family physician was Dr. John Adams who drove, in those days, a wonderfully fine team of horses. As though it were yesterday, I see vividly in my impressionable boyhood memory Dr. Adams come racing around the corner of Tower Avenue, pause to look at the cross street,—a sea of that red mud, turn his horses on to the old wooden sidewalk and continuing at a breakneck speed, drive up to the house next door. I remember so well thinking at the time, seeing the horses all in a lather, panting for breath, the whip fallen to the yard,—oh, how cruel—how could he so misuse that wonderful team. It was not until that evening when I had related my impressions to my father, that I learned for the first time that the wife of our neighbor had been on the threshold of death itself,—that it had possibly been the fact that the doctor did have a team that could make such a sacrifice, that she owed her life. I know now, as I did not on that day, that Dr. Adams' horses were his pets,—that they received his best care,—that he held them in almost affectionate regard.

So, Mr. Chairman, before we can determine whether an act is cruel, we must know more than the act itself, we must know the circumstances that surround that act.

I am a lover of the outdoors. I have never shot a deer and I know that I never could do so,—entirely aside from the question of marksmanship. My brother and I have owned three dogs in our lives. Yet, Mr. Chairman, I have a baby girl who has just passed her second birthday. If, by experimentation upon animals, to be done, I would hope, with every possible degree of humaneness, I even thought that some minor discovery could be made that would in any way protect the health or prolong the life of that baby, I would hold her future and the future of every other child of greater consequence than the life of a dog.

In itself, it is not pleasant to think of a rabbit running a treadmill as an experiment. But if we know that the experiment was performed because it was felt that fatigue was in a measure responsible for some types of insanity and that it was just barely possible that out of that experiment, or some kindred experiment, would be gained one more thread of knowledge that might lift the veil of a living death for just one Wisconsin citizen,—then we have an added fact that presents a new yardstick by which we are to measure what is in fact cruel.

So would I emphasize to you this afternoon that no one should condone cruelty whether it be committed by a research worker or an ignorant man. We cannot measure cruelty, however, unless we know the facts surrounding the experiment.

Now if I may return to the first argument of the proponents which may be said to be that it cannot be shown that humanity has benefited from past experiments and thus will not benefit from future animal experimentation.

I know that they cannot know that it was the dog that gave the medical profession its essential information about blood pressure. It was the dog that made it possible for Dr. Banting to give to the world insulin that has so tremendously prolonged the life of every diabetic patient. The experiments of Dr. Banting could have been performed on no other animals. And again it was the dog that made possible changing the word "anemia" from a sentence to slow death to a life that can be greatly prolonged through the use of liver and liver extracts.

Now, Mr. Chairman, this matter of prolongation of life, if only for a year, is of momentous conse-

quence. Such diseases as diabetes generally attack man during the ages when we generally think of him being at the prime of his life,—the period of the forties and the early fifties. It may be said that his greatest work is before him. His children are likely still in school. He has not yet secured a competence for his family. He has but started to give of his most productive years for society. Think for a moment what it means to have such a man die so prematurely.

My father had diabetes. I feel that I am within reason when I say that had it not been for insulin he could never have given of his talents on the Supreme Court of this State. Insulin prolonged his life those many years. Those additional years were the richest in my own life,—they were productive for him and for society.

I need not tell you when these two great discoveries were made. I place before you charts of the death rate in our own state from diabetes and anemias. You need no interpreter to point out that something suddenly happened to cause that steadily upward swinging line of deaths of man at the prime of life abruptly to turn down. That something was two great discoveries, the one made in Canada, the other in the United States, that has prolonged the life of hundreds of our own Wisconsin neighbors, and of many thousands in the short time that has elapsed since these discoveries have been made known. These discoveries depended upon animal experimentation upon dogs. Is this not sufficient evidence to controvert the arguments of the proponents of this bill?

Others who follow me can tell the story far more graphically than can I,—will supply the details which you will wish and answer your questions.

I have tried to point out only that the proponents of this legislation, sincere in motives, have based their case upon faulty reasoning and knowledge. They do not believe that the human race has benefited from animal experimentation, hence all experimentation is brutal. You must agree with them on both counts if you are to adopt this legislation and I do not believe that you are ready to supplant knowledge with a faith unfounded.

I would remind you that there exists upon the statute books of this state ample legislation against inhuman treatment of animals; that any humane officer of the state may, upon his request, be admitted to the laboratories of Marquette or our state University. The question before you is not that of cruelty but of prohibition,—a prohibition that the proponents of the measure will admit as one that they would like to see extended to its widest application to cover every living form of life, which they have limited in this bill to the dog only as the expedient means of securing initial legislation which can be broadened in the future.

LAY REGENT OPPOSES BILL

Judge A. C. Backus: Mr. Chairman and members of the Committee. I appear as a citizen of the State of Wisconsin to voice my protest against this bill. I pay my own expenses, and my interest in appearing here is only one that every citizen who is interested in the welfare of mankind should take. We, the laymen, strenuously disapprove and resent the unjust attacks made by some unscrupulous, wilful obstructionists upon the scientists and doctors. We are here to extend our appreciation to the scientists for the wonderful discoveries and progress they have made. We are indeed grateful to them for their untiring efforts in trying to save and prolong human life. Irrespective of this proposed bill before the legislature, we want the doctors, scientists and instructors to feel that the intelligent people of the State of Wisconsin are applauding their work.

The questions one naturally would ask are: Why is it necessary in this state to call for a measure so far reaching as this one? What is the trouble in the State of Wisconsin? Are dogs being mistreated, or animals tortured to death for the sake of torture? If so, why has not the present law on "cruelty to animals" been enforced? Why not bring to justice those men (if it is true) who are in the habit of torturing or treating animals cruelly? I have been a member of the Humane Society of the city of Milwaukee for a great many years. I prosecuted vigorously, when I was district attorney of Milwaukee county, men who have tortured animals, and as a judge I have sent to the penitentiary those who have been guilty of such conduct, and I am perfectly in accord with the good men and women who love the dog and all animals. Yet, in all the years while I was prosecuting attorney, and on the bench, and now as a member of the Board of Regents of the University of Wisconsin and on the Advisory Board of the Marquette University, I have never heard one complaint coming from any source to the effect that dogs are being mistreated or tortured in any of our medical schools in the State of Wisconsin. Doctors and instructors do not wilfully torture animals. It is not in their make-up. Knowing how they work and what they do in the classroom, I have a right to resent any such insinuations. I challenge the opposition to produce any evidence to that effect. We are entitled to have it here. Where is it? And where are the accusers? We expected to hear something from the proponents of this measure. We expected to hear some arguments that might throw light on this charge. This legislative body is sitting in solemn session, searching for the truth. This is a public meeting. Do our accusers fear the searchlight? We are ready to meet them. They are not here. Their silence is oppressive. All that has been presented are a few stereotyped petitions. I am amused to see how these petitions are being sent out in the State of Wisconsin,—the insidious manner in which members of the legislature are being approached on this measure by the so-called anti-vivisectionists is appalling. The back-door policy, so to speak, is being used to appeal to the members of this committee, and to the members of the legislature, all of which

is certainly unethical, distasteful and offensive. May I be permitted to read in part from a letter which was sent to the faithful urging that these petition blanks be filled out and sent on to the legislature? I shall read the concluding paragraph of this letter:

"In closing, briefly the plan is this: we want a sufficient number of these petitions signed so that the beginning of the first day of the legislative session we can mail to every senator and representative a petition daily, each containing thirty names. We want the legislators to find on their desk every morning a new petition. At first they will say,—it will be more or less of a joke. (Yes, a joke,—that is the way to treat the members of the legislature.) At first it will be treated by them more or less as a joke. Senators and representatives probably will say to each other in a humorous fashion, 'Did you get your dog petition today?' In a short time, however, it will cease to be funny, and we may expect remarks like this, 'Say, this dog exemption thing is getting serious,—look out. Are you getting a petition every day? Why, these dogs can't forget us.' They can't ignore us. This plan requires a great number of petitions. Let's be up and sign. Sincerely yours, The Wisconsin Anti-Vivisection Society. P. S. If you live outside of Wisconsin, won't you see to it that some friend in this state will send it out." I leave this letter with you, members of the committee, without further comment.

Way back in England, in the days of Lord Coke, petitions were always generously used to condemn people, and it was not infrequent where people would sign petitions promiscuously for the purpose of executing a fellowman, and I am told that in one instance it so happened that a man who was about to be condemned and executed signed one of these petitions.

Chairman: Judge, did they hang the man?

Judge Backus: No, the Court frowned upon the petition and rejected it. This committee has a right to frown upon the petitions presented here and to reject them, in view of the letter that has been sent out by the Wisconsin Anti-Vivisection Society.

I want to say at the outset to this committee, that I am a great friend of the dog. I own a dog and have spent as much money keeping my dog healthy, as I have spent on the members of my family. My dog has been sick with distemper. He has had a broken leg. He was run over by an automobile, and has been in a great deal of trouble. I have treated that dog with a great deal of tenderness and care. I have given him all the service a veterinarian can give him. I have had him more than ten years and that dog will live with us until the end comes. I love animals, but I am not so narrow as to deny the right of doctors and scientists to experiment upon the animal in the interests of science. There comes a time in order to save the human race that animals must be sacrificed. We know of cases where man will sacrifice himself so that the oncoming generation may live a better and more vigorous life. The question has been raised—why sacrifice a dog. I suppose the answer would be that in certain cases a dog will better respond to the needs of the human being than any other animal.

Take it in rabies. It was best to take the dog for an experiment. In diphtheria it was best to take the horse. In smallpox the most effective serum was obtained from the cow. However, that matter will be discussed a little later.

We are all pleased to have listened to Professor Steenbock. He is one of the outstanding scientists today. His work in the laboratory and the discoveries that he has made will live for all time. While he is a great man, he seems to be a very modest man. We honor him for what he has done, and posterity will join in our gratitude. Scientists have not always had their full measure of appreciation while they were living. They work quietly in their experimentations, and why it is, I do not know, but their greatness is more and more recognized as the years pass.

If it is permissible, members of the committee, I desire to reflect for a few moments and call to mind some of the great scientists who have come and gone, and what they have done, to alleviate the sufferings of mankind. No man who has been progressive or who has made any discoveries, has escaped a great deal of unjust criticism and abuse.

Two hundred and fifty years ago an obscure man, whose name was Anthony Leeuwenhoek, looked for the first time into a mysterious world and discovered a thousand kinds of tiny beings. Among the people in his community he was known as the "lens grinder" of Holland. It was Leeuwenhoek who turned his lenses on a drop of rain water and discovered animals a thousand times smaller than any creatures you could see with the naked eye. This was the day of days. It was the beginning of a scientific investigation which has led to thousands of different discoveries ever since.

In 1729 Spallanzani, a Spanish scientist, took Leeuwenhoek's microscope and discovered the life and action of microbes.

In 1822 the great Pasteur was born in France. He discovered the virus and vaccine for rabies. You will recall when the dogs of Paris had hydrophobia. When the wolves and dogs of Russia were running mad, biting human beings and infecting them with rabies. Thousands of men, women and children were dying of hydrophobia. It was through the efforts of this great scientist, Pasteur, that the lives of millions have been saved because of the discovery of the vaccine and virus which was brought about through his experimentation on dogs. Pasteur not only saved human lives, but the lives of dogs as well. During the life of Pasteur a great deal of cheap criticism was aimed at him. Just the same kind of criticism that we hear against our scientists of today. However, the name of Pasteur lives in history and will live on for all time, while the names of his critics only lived for the moment. Pasteur

(Continued on page 310)

PRESS SERVICE OF STATE MEDICAL SOCIETY

No serum does so much for public health as printer's ink

AUTOMOBILE ACCIDENTS

Madison, Wis., Feb. 25.—Had Wisconsin's death rate from tuberculosis followed her auto accident toll since 1912, the 1930 tuberculosis death list would have numbered 88,575 souls instead of 1,490, according to the Committee on Public Health of the State Medical Society of Wisconsin.

The state's auto accident deaths have been recorded as such since 1912. In that year 21 deaths from auto accidents were reported, and in not one of the 18 subsequent years has a decrease been recorded from the toll of the preceding year, while the annual death list reached the appalling figure of 790 last year.

In 1912 Wisconsin suffered 2,362 deaths from tuberculosis, while the auto, still in its infancy, was causing the 21 state deaths. Last year but 1,490 deaths from tuberculosis were reported, and in all but seven years since 1912 new low records in this toll were established.

While last year's tuberculosis toll marked a decrease of three-eighths from the 1912 figure, the State Board of Health points out, the 1930 auto accident deaths were more than 37 times greater than those of 1912.

"If this terrible increase had occurred under the head of some recognized disease," the board's statement reads, "public protest would not cease until the medical profession had mastered the situation. The speed mania appears to be as much of a disease as any recognized ailment, but its cure must come from the public itself rather than from any effort, no matter how great, that our public health agencies or the medical profession can contribute."

PNEUMONIA RANKS THIRD

Madison, Wis., March 4.—Although pneumonia ranks first in nearly half of the states, Wisconsin has forced it into third place.

The State Medical Society in a bulletin issued today shows that the death rate per 100,000 for pneumonia in Wisconsin has declined from 107.9 per cent in 1923 to 77.2 per cent in 1929. Still greater percentages will be shown when the new figures are tabulated, according to the State Board of Health.

The following is a tabulation showing deaths from pneumonia and death rates per 100,000 population during the ten-year period from 1920 to 1929:

Year	Deaths	Death rate per 100,000
1920	2901	110.2
1921	2093	78.6
1922	2463	91.4
1923	2939	107.9
1924	2511	91.2
1925	2525	90.7
1926	2381	84.6
1927	1926	67.7
1928	2571	89.4
1929	2244	77.2

"The increase and decline in the death rate from pneumonia is so closely associated with influenza that the two diseases really should be considered together," declares the bulletin of the State Medical Society issued today. "There were no influenza outbreaks of any moment in 1930. Only 470 deaths from influenza have been reported to date compared with 1251 deaths in 1929, 1380 in 1928 and 613 in 1927. The comparatively high death rate in 1928 was unexpected and should not have occurred under the three-year rule until 1929. When a severe outbreak starts in the fall, it is almost certain to increase the death rate for that year and also for the next year. The outbreak in 1928 started in Wisconsin in November and probably traveled eastward from the West coast. The epidemic carried over into 1929 and caused an unusually large number of deaths for both years. Whether epidemics of influenza will occur every third year in the future, it is impossible to state. If this periodicity which we know is characteristic of the disease continues, we will have a moderate increase in the death rate in 1931 and the year 1932 will witness a high mortality rate which would not be equalled again until 1935. A drop in influenza mortality is always accompanied by a decline in the death rate from pneumonia."

SHOES AND THE FEET

Madison, Wis., March 11.—A tight-fitting stocking and a pinching shoe may cause as much discomfort as some physical deformity. If people generally would pay as much attention to the comfort of the shoes which they wear as they do to other garments, there would be fewer people complaining of foot trouble and broken arches.

The Educational Committee of the State Medical Society in a bulletin issued today declares that man was intended to walk barefooted, and all of the ailments of the feet are caused by people wearing shoes too tight and stockings fitting too snugly.

"One should bathe the feet once each day," declares the bulletin. "The soap used should be of a non-irritating variety and the foot should then be dusted with a non-irritating simple powder. For tired feet the addition of small quantities of salicylic and boric acid may be helpful.

"Today barefoot locomotion should be indulged in only in the sand or water. Bedroom sandals or ordinary slippers, as a rule, are harmful, and should not be used except to exercise the feet. There is considerable danger of picking up ring worm of the foot by walking barefooted, and this is especially true in places where large numbers of people walk without shoes.

"Since our modern civilization demands that we wear shoes, what is the best type of shoe to wear? From the point of view of foot hygiene the evidence is in favor of the high-cut rather than the low-cut shoe. Lace shoes are, as a rule, preferable to button. There has been much discussion in regard to the shank of the shoe, as to whether it should be flexible or rigid. Individuals without foot troubles may do very well in flexible shank shoes. Those who have foot troubles correctable by exercise only will do well in flexible shank shoes, but for that large number who need both exercise and support, a rigid shank shoe is, at least temporarily, of much greater value.

"The shoe should have a round toe, a medium width shank and should be made over a last with a straight inner border. The height of the heel should be within reasonable limits, for both extremes are undesirable, not only because of the effect upon the feet, but especially because of the effect on the back.

"Every individual should make it a practice to change his shoes during the day if possible. It is ad-

(Continued on page 310)

THE JOURNAL BOOK SHELF

The Medical Museum. By S. H. Daukes, M. D., director of the Wellcome Museum of Medical Research. An amplification of a thesis read for the degree of M. D., Cambridge. The Wellcome Foundation Ltd., 33 Gordon St., London.

Tropical Medicine in the United States. By Alfred C. Reed, M. D., Professor of Tropical Medicine, The Pacific Institute of Tropical Medicine within the George Williams Hooper Foundation for Medical Research of the University of California. J. B. Lippincott Company, Philadelphia.

Burns. Types, Pathology and Management. By George T. Pack, B. S., M. D., fellow of the Memorial Hospital, New York City; formerly professor of pathology and lecturer in minor surgery, The School of Medicine, University of Alabama; and A. Hobson Davis, B. S., M. D., instructor in pathology, University of Alabama. 60 illustrations. J. B. Lippincott Company, Philadelphia and Lonodn.

Handbook of Anatomy. By James K. Young, M. D., F. A. C. S. Revised by George W. Miller, M. D., F. A. C. S. Seventh Revised Edition. With 154 Engravings. Philadelphia, F. A. Davis Company, 1930.

Injection Treatment of Internal Hemorrhoids. By Marion C. Pruitt, M. D., associate in surgery, medical department, Emory University. Illustrated. Price $3.00. C. V. Mosby Company, St. Louis, 1929.

Hemorrhoids, The Injection Treatment and Pruritus Ani. By Lawrence Goldbacher, M. D., Philadelphia. Illustrated with 31 half-tone and line engravings. Price $3.50 net. F. A. Davis Company, Philadelphia, Pa.

Blood and Urine Chemistry. By R. B. H. Gradwohl, M. D., director of the Gradwohl Laboratories, St. Louis and Ida E. Gradwohl, A. B., instructor in the Gradwohl School of Laboratory Technic, St. Louis. With 117 illustrations and 4 color plates. Price $10.00. C. V. Mosby Company, St. Louis, 1928.

Episcopal Hospital Reports. Volume VI, commemorating the 75th year of the Hospital of the Protestant Episcopal Church in Philadelphia. Press of Wm. J. Doran, Philadelphia, 1930.

Outline in Obstetrics for Nurses. By F. W. Rice, M. D., instructor in obstetrics, Iowa Methodist Hospital and Broadlawns General Hospital, Des Moines. Price $2.00. C. V. Mosby Co., St. Louis.

Legal Medicine and Toxicology. By Ralph W. Webster, M. D., published by W. B. Saunders Co., 1930.

Manual of the Diseases of the Eye. For students and general practitioners. By Charles H. May, M. D. Director and visiting surgeon, eye service, Bellevue Hospital, New York, 1916 to 1926. Thirteenth Edition, revised. With 374 original illustrations, including 23 plates and 73 colored figures. Price $4.00 net. William Wood and Company, New York.

A Text-Book of Gynecology. By Arthur Hale Curtis, M. D., professor and head of the department of obstetrics and gynecology, Northwestern University Medical School; chief of the Gynecological Service, Passavant Memorial Hospital, Chicago. 222 original illustrations. W. B. Saunders Company, Philadelphia and London, 1930.

Abdomino-Pelvic Diagnosis in Women. By Arthur John Walscheid, M. D., Director of Obstetrical and Gynecological Department of Broad Street Hospital; Director of Obstetrical and Gynecological Department of Pan-American Medical Center and Clinics, New York City; Consultant in Gynecology and Obstetrics to Margaret Hague Maternity Hospital, Jersey City, N. J.; Consulting Gynecologist to Bergen County Hospital, Ridgewood, N. J.; Consulting Gynecologist to the F. Reuter Home, North Bergen, N. J.

Operative Gynecology. By Harry Sturgeon Crossen, M. D., F. A. C. P., professor of clinical gynecology, Washington University School of Medicine; gynecologist in chief to the Barnes Hospital and the Washington University Dispensary. And Robert James Crossen, M. D., instructor in clinical gynecology and obstetrics, Washington University School of Medicine. 4th edition. 1246 illustrations and 2 color plates. Price $15.00. C. V. Mosby Co., St. Louis, Mo.

The Treatment of Fractures. By Lorenz Böhler, M. D., Chief Surgeon and Director of the Vienna Accident Hospital. Authorized English translation by M. E. Steinberg, M. S., M. D., of Portland, Oregon. Formerly senior officer on the surgical service of the U. S. Public Health Service Hospital, and consultant surgeon to the U. S. Veterans' Bureau at Portland, Oregon. With 234 illustrations. Vienna, Wilhelm Maudrich, 1929.

Grow Thin on Good Food. By Luella E. Axtell, M. D. 12Mo, Cloth. 344 pages, illustrated, indexed. Price $2.00. Funk & Wagnalls Company, New York.

How it Happened. By Adalbert G. Bettman, M. D. Price $1.00 net. F. A. Davis Co., Philadelphia.

Allergic Diseases. Their diagnosis and treatment. By Ray M. Balyeat, M. D., F. A. C. P. Director of the Balyeat Hay-Fever and Asthma Clinic, Oklahoma City. Illustrated with 87 engravings, including 4 in colors. Third edition, revised and enlarged. Price $5.00 net. F. A. Davis Company, Philadelphia.

Intestinal Toxemia. By Anthony Bassler, M. D., F. A. C. P., consulting gastroenterologist, St. Vincent's, Peoples' and Jewish Memorial Hospitals, New York City; St. John's Hospital, Yonkers; Christ Hospital, Jersey City. Illustrated with 16 text cuts. Price $6.00. F. A. Davis Company, Philadelphia, 1930.

Normal Facts in Diagnosis. By M. Coleman Harris, M. D., lecturer on physical diagnosis. New York Homeopathic Medical College and Flower Hospital and Benjamin Finesilver, M. D., lecturer on diseases of the nervous system, New York Homeopathic College and Flower Hospital. Illustrated with forty-two engravings, some in colors. Price $2.50 net. F. A. Davis Company, Philadelphia.

Text-Book of Medicine. Edited by Russell L. Cecil, M. D., assistant professor of clinical medicine in Cornell University; assistant visiting physician in Bellevue hospital, New York City. Associate editor for diseases of the Nervous System, Foster Kennedy, M. D., professor of neurology in Cornell University. Second edition, revised and entirely reset. 1592 pages. W. B. Saunders Company, 1930. Cloth $9.00.

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29th and Ellis Ave., Chicago, Ill.

Doctor and Patient. By Francis W. Peabody. M. D., Professor of Medicine, Harvard Medical School, director of Thorndike Memorial Laboratory, visiting physician and chief of the fourth medical service, Boston City Hospital 1921 to 1927. Price $1.50. The Macmillan Company, New York.

Microbiology and Elementary Pathology. By Charles G. Sinclair, B. S. M. D., Major, Medical Corps, U. S. Army. Instructor in bacteriology, Army Medical School. With 102 illustrations, some in colors. Price $2.50 net. F. A. Davis Company, Philadelphia, 1931.

Doctors and Specialists. A medical revue with a prologue and a good many scenes by Morris Fishbein, M. D., editor of Journal of the American Medical Association and Hygeia. Price $1.00. The Bobbs-Merrill Company, Indianapolis.

Physical Diagnosis. By Warren P. Elmer, B. S., M. D., associate professor of clinical medicine, Washington University, and W. D. Rose, M. D., late associate professor of medicine in the University of Arkansas. With 337 illustrations. Price $10.00. C. V. Mosby Company, St. Louis, 1930.

A Manual of Normal Physical Signs. By Wyndham B. Blanton, B. A., M. A., M. D., assistant professor in medicine, Medical College of Virginia. 2nd edition. Price $3.00. C. V. Mosby Co., St. Louis, 1930.

Treatment of Epilepsy. By Fritz B. Talbot, M. D., clinical professor of pediatrics, Harvard University Medical School; chief of Children's Medical Department, Massachusetts General Hospital. Price $4.00. Macmillan Company, 60 Fifth Ave., New York, 1930.

A Compend on Bacteriology. By Robert L. Pitfield, M. D., attending physician, Germantown Hospital, Philadelphia. And Howard W. Schaffer, M. D., pathologist to the Memorial Hospital, Philadelphia; fifth edition, 82 illustrations and 4 plates. Price $2.00 net. P. Blakiston's Son & Co. Inc., 1012 Walnut St., Philadelphia.

Chronic Arthritis and Rheumatoid Affections. By Bernard L. Wyatt, M. D., F. A. C. P., director, The Wyatt Clinic; formerly associate director, The Rockefeller Commission to France. Price $2.50. William Wood & Company, 156 Fifth Ave., New York.

Diseases of the Digestive System, Volumes I and II. By L. Winfield Kohn, M. D., F. A. C. P. Formerly assistant in the gastro-intestinal clinic, Johns Hopkins Hospital; chief of the clinic of gastro-enterology, Medico-Chirurgical College, Philadelphia; present chief of the gastro-intestinal clinic, Lebanon Hospital, New York City. Illustrated with 542 engravings, including 7 full page colored plates. Price of two volumes $12.00 net. F. A. Davis Company, Philadelphia, 1930.

Clinical Obstetrics. By Paul T. Harper, Ph. B., M. C., Sc. D., F. A. C. S. Fellow of the American Association of Obstetricians, Gynecologists, and Abdominal Surgeons, and of the New York Obstetrical Society. Clinical Professor of Obstetrics, Albany Medical College. Regional Consultant in Obstetrics, New York State Department of Health. Illustrated with 84 plates of engravings (250 figures) with legends and charts. Philadelphia F. A. Davis Company, Publishers, 1930.

Clinical Laboratory Methods. By Russel L. Haden, M. D., Professor of Experimental Medicine, University of Kansas, School of Medicine. Third edition. Price $5.00. C. V. Mosby Company, St. Louis, 1929.

Practical Psychology and Psychiatry. By C. B. Burr, M. D., Sixth edition. Price $2.75 net. F. A. Davis Co., Philadelphia, Pa.

Insomnia. By Joseph Collines, M. D. Price $1.50. D. Appleton and Company, New York.

BOOKS RECEIVED FOR REVIEW

Easier Motherhood. By Constance L. Todd. Price $2.00. John Day Company, Inc., 386 Fourth Ave., New York, N. Y.

Textbook of Human Embryology. By Cleveland Sylvester Simkins, Ph.D., associate professor of anatomy, University of Tennessee Medical School, Memphis. 263 illustrations, some in colors. Price $4.50 net. F. A. Davis Company, Philadelphia. 1931.

Selections from the Papers and Speeches of John Chalmers DaCosta, M.D., LL.D. Samuel D. Gross professor of surgery at the Jefferson Medical College, Philadelphia. 440 pages. Cloth, $6.50. W. B. Saunders Co., Philadelphia and London.

Cancer: Its origin, its development and its self-perpetuation. The therapy of operable and inoperable cancer in the light of a systemic conception of malignancy. A research by Willy Meyer, M. D., consulting surgeon to the Lenox Hill and Postgraduate Hospitals, New York Infirmary for Women and Children, etc., emeritus professor of surgery, N. Y. Postgraduate Medical School. Price $7.50. Paul B. Hoeber, Inc., New York, N. Y.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Secretary, Mr. J. G. Crownhart, 119 E. Washington Ave., Madison, Wisconsin. These new books will be loaned for an inspection period only.

Infant Feeding in General Practice. By J. V. C. Braithwaite, M. D., M. R. C. P. (Lond.), physician and physician in charge of Children Out-patients, Leicester Royal Infirmary and Children's Hospital; late assistant Queen's Hospital for Children, London. Price $1.75 net. William Wood & Co., 156 Fifth Ave., New York, N. Y.

A little book on infant feeding written by an English general practitioner for the guidance of general practitioners. The book is simply, even entertainingly written; exhibits a good practical knowledge of feeding; gives some very wholesome advice but does not even pretend to impart anything that is new. The book may find a field of usefulness in England, but it is almost impossible to imagine anything but a very limited demand for it in this country. A. L. K.

A Manual of Diseases of the Nose, Throat and Ear. By E. B. Gleason, M. D., professor of otology, Graduate School of the University of Pennsylvania.

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Sixth edition, thoroughly revised. 12 mo. of 617 pages with 262 illustrations. Cloth $4.50 net. W. B. Saunders Company, Philadelphia, and London.

This is the sixth edition of Gleason's work, the first having been published in 1907. The book is well written and should be of particular interest to the student of ear, nose and throat, both undergraduate and graduate.

The anatomy and physiology and pathology of ear, nose, and throat conditions are well discussed in an interesting way and the treatment both operative and non-operative is up-to-date over the last edition. As in the other editions there is an appendix of thirty-seven pages of prescriptions or formulas for ear, nose, and throat conditions, these also having been brought up-to-date. I feel that it is a very valuable handbook for ear, nose, and throat. T. L. T.

Nursing Technic. By Mary C. Wheeler, R. N., former superintendent of Illinois Training School for Nurses; and Amalia Metzker, R. N., instructor, St. Luke's Hospital School of Nursing, Racine. Third edition completely revised and reset. J. B. Lippincott Co., Philadelphia.

The book is complete and practical in the teaching of the fundamentals of nursing technic and will help to more nearly standardize the work in schools of nursing. A. D.

Clinical Allergy, Particularly Asthma and Hay Fever. By Francis M. Rackemann, M. D., physician to the Massachusetts General Hospital; Instructor in medicine, Harvard Medical School. Price $10.50. The Macmillan Co., 60 Fifth Ave., New York City.

This survey of a very complicated medical field is carried out with unusual clarity. The general arrangement will appeal to the average practitioner with its emphasis on the practical features of diagnosis and treatment, and yet, the comprehensive bibliographies following each section will be of value to the smaller group particularly interested in this field. The disappointments and failures of diagnosis and treatment of allergic conditions is discussed with satisfying frankness. J. H.

Ante-Natal Care. By W. F. T. Haultain, O. B. E., M. C., M. B., senior assistant obstetric physician and late special assistant to ante-natal departments, Edinburgh Royal Maternity and Simpson Memorial Hospital. And E. Chalmers Fahmy, M. B. (Edin.), assistant obstetric physician and special assistant to ante-natal department, Edinburgh Royal Maternity and Simpson Memorial Hospital. Second edition. Price $2.25 net. William Wood & Co., 156 Fifth Ave., New York, N. Y.

The second edition of this little book is indeed a gem in medical literature. It is written in a simple straight forward style, and pleasingly devoid of useless argumentation.

The collection and arrangement in one book of all the problems pertaining to pre-natal care, rather than the numerous references scattered through a text book on obstetrics, gives this subject the dignity and importance it has long deserved.

To the physician whose pre-natal care consists of a single examination of the urine and a pat on the back with the assurance that everything is fine, this little compressed collection of facts will and should come as quite a shock.

While not intended as a text for medical students, this book should be owned and read by every physician practising obstetrics. N. E. M.

Modern Methods of Treatment. By Logan Clendening, M. D., professor of clinical medicine, lecturer on therapeutics, medical department of the University of Kansas. Fourth Edition. Price $10.00. C. V. Mosby Company, St. Louis, Mo.

The fourth edition of this comprehensive volume on medical treatment shows no significant changes from the preceding edition except perhaps in the section on diabetic coma. The author has gathered together practically all of the standard therapeutic procedures in the armamentarium of the medical practitioner of today and has discussed them first individually and then in their application to the treatment of specific diseases. He is to be commended for reminding us that the art of treating disease consists not only of the prescription of drugs and the use of surgical measures, but that dietetics, physiotherapy, radiotherapy and psychotherapy all have an equally important role. The sections on dietetics and psychotherapy are especially well done. To cover in a single volume the entire field of medical treatment is well recognized to be an almost impossible task but the author has made a noteworthy attempt. F. W. M.

Chinin In Der Allgemeinpraxis unter Berucksichtigung Pharmakologischer Befunde. By Dr. Med. Fritz Johannessohn. On demand, copies will be sent to medical men free of charge. Address, Bureau for Increasing The Use of Quinine, P. O. Box 215, Amsterdam-W, Holland.

The author, Johannessohn, has compiled from the literature of the past 15 years, in a very comprehensive and careful manner, the parasitotrope and organotrope effect of quinine. Notwithstanding the fact that the intention of the publication is to acquaint readers with the use of this alkaloid, it is free from exaggerating propaganda statements and offers an objective description of the therapeutic value of the drug. A large index of the literature increases the value of the booklet.

G. R. E.

Modern Surgery. By J. Chalmers DaCosta, M.D., LL.D., F. A. C. S., Samuel D. Gross professor of surgery Jefferson Medical College, surgeon to Jefferson Medical College Hospital, consulting surgeon to the Philadelphia General Hospital, St. Joseph's Hospital and Misericordia Hospital, Philadelphia. Assisted by Benjamin Lipshutz, M. D., F. A. C. S. Surgeon to the Mt. Sinai Hospital; associate in neuro-anatomy, Jefferson Medical College. Tenth

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SAINT PAUL
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Edition, revised and reset. 1404 pages with 1050 illustrations, some in colors. Philadelphia and London: W. B. Saunders Company, 1931. Cloth, $10.00.

Since the first edition published in 1894 it has been the standard text-book in America, with each edition new work has been added which appeared to the author to be logical and safe.

The text is based on physiology and pathology and the surgical principles that have stood the test of experience. Throughout the book one finds references to the important surgical literature of the world.

In each chapter is found the opinion of Professor DaCosta as in gastric ulcer: gastro-enterostomy should never be practiced unless the ulcer "is visible, palpable, and demonstrable; since the mortality of partial gastrectomy is from 5 to 10 per cent in the hands of its warmest advocates, it seems clear that the mortality from gastrectomy will be higher than the combined mortality of gastro-enterostomy and the incidence of gastrojejunal ulcers after such an operation, we know the worst of gastro-enterostomy, the best is insurpassable, we have yet to learn the worst of gastrectomy."

In perforated duodenal ulcer, "personally I do not practice excision of the ulcer, as I believe that closeure is just as permanently useful and is safer. If the operation is performed within twelve hours of the perforation, perform gastro-enterostomy as well as closure of the perforation even if there is no stenosis, and after inspection of the liver, spleen and gall bladder, the appendix must be removed."

In acute pancreatitis, "I think we should operate at once, even in shock as 95 per cent of the cases not operated upon die, indicates the necessity of urgent, early surgical intervention. The operative mortality in the stage of edema without fat necrosis is 23 per cent, with fat necrosis the mortality is 60 per cent."

In exophthalmic goiter, "the great value of iodine is as a preparation for operation and its use post-operatively to prevent the post-operative thyrotoxic crisis. Iodine does not benefit the patient permanently, and if the physician wishes to cooperate with the surgeon, he should not give iodine as a cure, for it may and usually does prove harmful.

"If iodine is used properly before, during and after operation it is rare to see thyrotoxic crisis."

The chapter on diseases and injuries of bones and joints is a masterpiece. "In ununited fracture of the femoral neck an autogenous bone graft as a rule should only be used when a fair amount of the neck of the femur is left, and where the patient is not more than 55" and states that Lexer who first used bone peg for fixation in fracture of the femur has given up the method because of the fracture and absorption of the graft, and quotes Albee with 90 per cent of excellent or good results in 36 cases."

Modern Surgery is written by the distinguished professor of surgery, from his clinic come important facts, real ideas and brilliant men, and as a text-book in surgery it has no equal in the English language. W. J. C.

MEDICAL LIBRARY SERVICE

AROUND THE LIBRARY, II

The second division of the recently established Medical Library—the Medical Library Service is already familiar to many physicians of the state. Its facilities and various services have been described in previous articles in this column. The Medical Library Service, as it is sponsored by the Medical School and the Extension Division of the University of Wisconsin, is the second service of its kind to be established in the United States.

The first steps in the development of Medical Extension work were taken in Iowa about ten years ago. The State Historical Library at Des Moines had accumulated a great number of valuable medical books and periodicals through gifts from individuals and from small libraries throughout the state. There was a feeling that this valuable material should be made available for the medical profession there. It remained for the present librarian here to organize that material and to put it into the hands of the practising physicians of Iowa. In the five years from 1923 to 1927 the total loans made by the library were 34,045. The service had grown from 2,587 loans for the year ending June, 1923, to 10,778 for the year ending 1927.

In 1927 a similar service was inaugurated in Wisconsin by the University. Iowa was the first state to organize such a service; Wisconsin was the first University to develop it. The organization as it exists here is known to you. The ideal toward which it is directed is that of complete library facilities for every physician of the state. Extension libraries for the legal profession have been known for many years. This library service offers an opportunity for the first time to assist the cause of common health through the individual members of the medical and allied professions. It has proven so valuable that other states have followed our example; Colorado and Oregon have developed libraries along similar lines within the last year.

If you have suggestions which you feel will help us to improve our service in any way, do not hesitate to express your ideas to us. The service is yours; your needs determine the nature of our organization. Our files are added to at your suggestions. Of the 223 periodicals received on subscription from the publishers and gratis from the state medical society, 112 are borrowed regularly. In December, 1928, there were 90 "regular" borrowers. In December, 1929—105; in December, 1930—174. At the present time we have 70 different physicians listed to receive personal service on specific

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subjects which they have indicated. Are you using these facilities? This service is sponsored by your state University for you. Why not take advantage of the opportunities offered? G.B.

PRESS SERVICE

(Continued from page 301)

visable too that the same pair of shoes be not worn two days in succession. Shoe trees or shoe forms are valuable aids in keeping footwear in shape. Rubber heels are of distinct advantage in minimizing repeated shocks to the feet, legs and spine. Metal arch supports as a rule are highly inadvisable because they act as props or crutches and do not increase the power of the supporting structures of the foot.

"It is of great importance that stockings fit well. Those that are too short have a tendency to produce ingrown toe nails, metatarsal arch trouble, hammer toes and bunions, while those too large curl up, form wrinkles and cause uneven pressure, which may result in irritated areas. Stockings should be changed daily."

DISEASES OF THE HEART

Madison, Wis., March 18.—A chart showing the increased percentage of diseases of the heart looks like a profile view of the Rocky Mountains, declares a bulletin issued by the Educational Committee of the State Medical Society today.

Starting on the left hand side in a low plateau, it rises jerkily up and up, until the final peak takes it off the paper.

"That is the rising menace of diseases of the heart," declares the bulletin. "Heart diseases kill a larger percentage of people every year. It has gradually outstripped Bright's disease, pneumonia, cancer, and even tuberculosis.

"For a long time the principal cause of death in this country was the Great White Plague, tuberculosis. So terrible was its devastation that man took up the challenge and organized the forces of science, medicine, education and social service to fight back. It was a glorious campaign and we are still hard at the mopping up process. Tuberculosis has not been eradicated, but it has been brought under control and robbed of much of its terror. Hundreds of thousands whom it would have struck down have been saved to life and usefulness. As a cause of death it has been reduced, in the last fifty years, from first place to fifth, and in some communities to seventh place.

"We have not yet stemmed the onward rush of heart diseases. That will take many years, since the concerted fight against it is so new and so many cases begin far back in childhood. Also there is so much about it that we have yet to learn. One reason for its increase is the happy fact that people are being saved from other diseases. The normal span of life has been lengthened since the Civil War by twenty years. As heart diseases slay nine-tenths of its victims after they have passed the age of forty, this means that the more people we keep alive until middle age and later the more possible targets we have among us for this insidious enemy.

"One of the reasons why it has been so difficult to fight is that it is in reality not one disease, but many, with different causes, different symptoms and different methods of prevention and treatment. We cannot draw up one system of rules, as in the case of tuberculosis, and hammer them in until the public is educated.

"There is common belief, for instance, that a heart sufferer may drop dead at any moment. This is a pitiful mistake; very few die suddenly from heart diseases. Usually there is first a long period of invalidism.

"Many can make a complete recovery and regain health, provided they follow the rules."

CONVULSIONS

Madison, Wis., Feb. 18—Convulsions are among the most common events in the lives of infants and may be serious, although they seldom result in death at the time of their immediate occurrence. The Educational Committee of the State Medical Society today issued a warning directing mothers to loosen the clothing of any child during any spasmodic movements.

"All clothing should be loosened or, better, removed so as to have nothing to interfere in any way with breathing," declares the bulletin of the medical society. "It is helpful to promote the flow of blood to the surface of the body by immersion in a very warm bath (not over one hundred (100) degrees Fahrenheit) or by a hot mustard pack. This consists of a folded sheet wrung out of hot water containing a teaspoonful of dry mustard to three gallons of water; the sheet is wrapped about the infant with a blanket over it. The purpose of these measures is to draw the blood to the skin capillaries and away from the brain. At the same time cold cloths may be applied to the head.

"If the child has repeated convulsions the doctor may instruct the mother how to use certain anesthetics to relieve the spasm. Of course, the doctor should always be called at once, although it is seldom that he is able to reach the home before the immediate trouble is over. The most important thing is to find out the cause of the spasm and, if possible, to remove that cause, but that is the function of the doctor. The mother, nurse or other attendant can only assist. This she can do most effectively by carefully observing every action and movement of the child and as soon as she has opportunity, making careful notes of all she has observed.

"It is a most alarming and upsetting event for a baby to have a convulsion and any mother is to be excused for losing her head at such a time. But, as in any other emergency, if she can remember that much depends on how completely she can control herself, be motivated not by her fright but by a determination to keep as calm as possible and to do those things to be done, she will be rendering the best service to her child. When she has been told what to do by the doctor, she should carry out his instructions carefully and methodically and expeditiously. Fortunately, in most convulsive attacks the child is not in any danger of immediate harm no matter how dreadful the condition seems to be, and even if nothing is done excepting to place it in a comfortable, safe position on the bed or floor, the outcome will be satisfactory. It is much better at such a time to do too little than to do too much."

ARGUMENTS AGAINST ANTI-VIVISECTION

(Continued from page 300)

was not a cruel man, but a man of a very kindly disposition. He did not kill dogs wantonly or wilfully. It is said that he went out of his way to inoculate the dog with the vaccine to cure him. What a benefactor he has been to the human race. When Leeuwenhoek discovered his lenses, his neighbors called him silly, mulish and simple. Nobody would listen to him, and when Spallanzani discov-

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed care Wisconsin Medical Journal.

WANTED—To form partnership with established physician doing some general surgery. Milwaukee preferred. Have an attractive proposition especially if interested in industrial work or small clinic. Will personally interview anyone who may be interested. Write No. 825 in care of the Journal. MAM

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ered the microbe and announced it to the world, his friends believed that he was insane, and there was serious consideration given as to whether or not petitions should be signed for the purpose of sending him to an insane asylum. I am afraid that our anti-vivisectionists would have been ready to have condemned the great Pasteur because he experimented on the dog. These great men dedicated their lives to science and the sacrifices they have made for the sake of humanity will live as long as civilization endures. Robert Koch, of Germany, discovered the tubercle bacillus. Ross and Grasse gave us the antitoxin to cure malaria. Bruce discovered the microbe which causes Malta fever, and Walter Reed saved untold numbers of human beings in his fight against yellow fever. Jesse Lagear gave his life by permitting a mosquito to bite his arm in order to prove that the mosquito is the carrier of the yellow fever germ. Theobald Smith discovered the cure for Texas fever, which had killed nearly all the cows in the southland, but before Theobald Smith was able to discover the cure, he had to experiment on thousands of cows. Many were doomed to die before he was able to establish his cure. Is Theobald Smith to be condemned because it was necessary to kill a few cows in order to save the lives of millions of healthy cows?

I could mention the names of hundreds of others who, up to the present time, have done much for us in their experimentations in their laboratories, but time will not permit me to go on.

Colonel Chamberlain of the Medical Corps of the United States Army, says: "Vivisection has had much to do to prolong the life of the human race. Experiments which have led to the finding and use of antitoxin against diphtheria have greatly reduced our death rate, and the improvement in prevention of intestinal diseases, especially typhoid fever. The experiments for the development of science can be carried out on small animals, but certain experiments have to be carried out on large animals, notably on dogs."

Dr. Kerr, in referring to surgery, says: "The advance of surgery of the intestines is due almost exclusively to the experiments on dogs, because dogs have the kind and size of intestines which correspond largely to those of man, and the lessons from them can be applied almost directly to man. If experimentation on dogs were to stop, science would immediately result in cessation of progress. We are constantly finding new things."

To come to more recent times, we have the discoverer of insulin, a modern treatment of diabetes, which was discovered entirely by experimentation on dogs. This also holds true with reference to pernicious anemia.

In 1855 Addison described a malady which has since been called Addison's disease, and postmortem examinations showed that in this affliction the suprarenal glands were diseased.

As has already been pointed out to the committee by Dr. Meek, Dr. Rowntree of Rochester, Minnesota, only two weeks ago discovered a remedy which will give relief to those suffering from this dread disease. Dr. Rowntree is constantly experimenting on dogs, and what a welcome message it will be to the world when his remedy is completed.

The great progress which has been made recently in typhoid cases would have been lost and thousands of lives sacrificed, if doctors and scientists were not permitted to experiment on the dog.

It has been stated by the "antis" that: "God has created animals to live on this earth, and it is not for man to seize and destroy." My version of the Bible is just a little different. "Man shall have dominion over the fowls of the air, the beasts of the land and the fish of the sea."

I notice that our genial complainant wears a fur coat. I wonder if it occurred to him that the fur was taken from animals who were caught in traps and died in torture. That the wool in his suit of clothes belongs to the sheep, and that the leather in his shoes comes from the hides of animals. That every time he eats an egg, he destroys a future chicken. That the honey he eats, he steals from the little bee, and that the milk he drinks, he robs from the calf. God has also created the Eskimo in the Arctic. Why not have the Society of Anti-Vivisectionists send the poor Eskimos paper suits and lettuce so that they may keep from freezing?

Proceeding now with my argument. Leishman devised a method of controlling the fatal camp disease known as typhoid fever, which has saved at least two hundred thousand of our troops in the Great War. Statistics show that during the Civil War every year out of 1,000 soldiers enrolled, 65 perished from disease. During the Spanish-American War the death rate was reduced to 30 out of every thousand, and during the World War, despite the epidemic of influenza, the rate was reduced to 14.8 per thousand.

One of the greatest triumphs of modern times—aseptic surgery, would be impossible without animal experimentation. The combined work of Pasteur and Lister has made modern surgery possible.

In 1876 Gussenbauer and Winiwater experimented on dogs' stomachs and were surprised to learn that by cutting out pieces of the stomach and sewing the remaining parts together, the parts united and grew together instead of being digested or destroyed by the gastric juice, as was the common belief.

In 1861 Billroth did the first successful pylorectomy on the human being. However, it was not until Nicholas Senn and Parks of Chicago, who experimented on a great many dogs by shooting them through the bowels or stomach while etherized, then operating on the wounds, proved that opening up the abdomen and sewing up the bullet holes was the best method of treatment.

Just stop and consider this one proposition alone: Can you realize how many lives have been saved because of this experimentation on the dog? A surgeon today would be derelict in his duty if he would fail to operate any person who was either cut or

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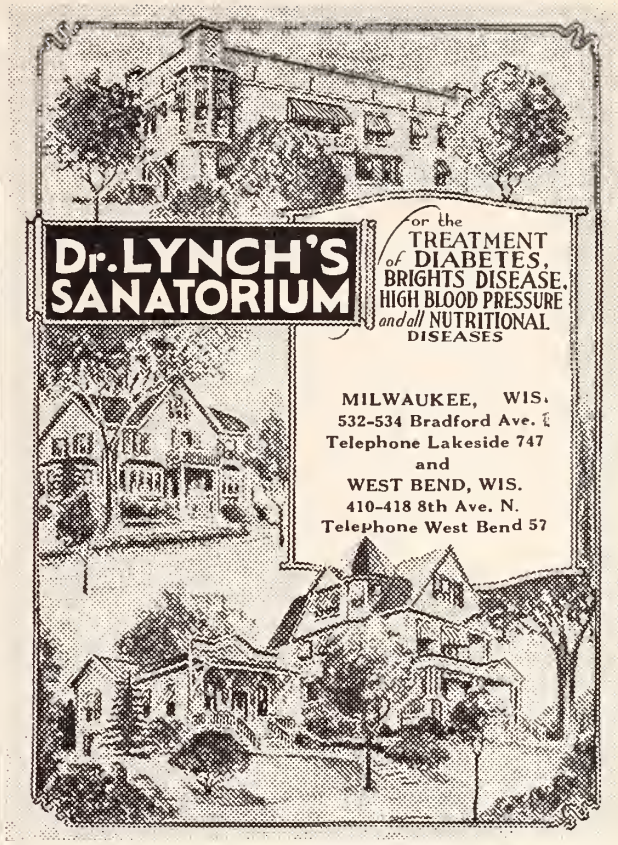

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shot through the intestines, or a person suffering from a perforated stomach.

Twenty-five years ago no surgeon dared to operate on the human heart, and yet today this is not infrequent. Carrell at the Rockefeller Institute has demonstrated the fact that in dogs the valve in the heart and the natural openings can be sewed up, enlarged, or reduced in size without killing the animal. Experiments are being continued today and the results will be far-reaching in aiding the medical profession.

Without animal experimentation, we must inevitably stagnate and many pressing questions as to the cause and prevalence of devastating epidemics of transmissible diseases, must remain unanswered.

I could go on indefinitely this afternoon and show conclusively that the great progress made in the scientific and medical world is largely due to experimentation on animals. Human life has been prolonged because of this method. I am told that the average life of the human being in 1789 was 35 years, in 1845, 40 years, in 1930, 55 years. I remember when I was a child twelve years of age, I was afflicted with the terrible disease known as diphtheria. That is over forty years ago. And I recall how the neighborhood and entire communities were wiped out by the disease. The doctors knew nothing of antitoxin in those days and they did the best they knew how at that time to combat this dread disease. I can recall that the epidemic was so severe that we could not get people in from our home town to bury the dead. It was a most terrible situation, beyond description, but thank God the scientists have discovered, through experimentation on dogs, a vaccine that will absolutely cure diphtheria, and no longer are communities wiped out by this awful disease, and if a patient does die of diphtheria today, the question immediately asked is: "I wonder why the doctor was not called in time."

I can recall in reading Ex-President Roosevelt's Travels in South America, he speaks of places where communities once lived, now completely wiped out because of yellow fever, or some other disease. People used to speak of these diseases, when visited upon entire communities, as a bad omen. Some would speak of it as the work of the devil. Today we know better. When thousands and millions have given up their lives all because of some germ carrier, we who are surviving can humbly bow in acknowledgment to scientists who have done a great and noble work. They have saved mankind from dread diseases, and will continue to do so in the future, and no obstacles or stumbling blocks should be put in their pathway, and no legislation, such as this proposed measure, should stop them in their progress.

We, the laymen, or common people, so-called, are grateful to Mr. Crownhart, secretary of the State Medical Society of Wisconsin, for advising us that this hearing would be on today. We are greatly indebted to him for his splendid activity in helping to defeat this obnoxious measure.

I am very glad to have had the privilege of meeting Dr. Meek and all the other doctors and professors and scientists here today, and I want to thank this committee for its patience in listening to me.

CORRIGAN ADDRESSES COMMITTEE

Mr. Crownhart: Mr. Chairman, there are many others to appear, but we appreciate the hour is getting late. We will file statements for all the others, except one who is here from Milwaukee and we would like to have just a minute or two for Mr. Walter Corrigan, Sr.

Mr. Walter D. Corrigan, Sr.: Mr. Chairman, and ladies and gentlemen of the Committee. I appear here as a citizen only and shall have to pay my own expenses unless my law partner, Judge Backus, who has just spoken, does it for me.

This is the most remarkable exhibition of pounding tacks with sledge hammers I have ever seen.

I come here particularly, ladies and gentlemen, as a matter of personal privilege, because in a very extraordinary way the idea has gone abroad in Wisconsin and amongst legislators and others, and has even reached some Congressmen down at Washington, that my family and I are so-called anti-vivisectionists. This propaganda so absolutely misrepresents our views, and particularly my own, that I feel it my duty as a citizen to come here and make a statement of my position. I do this notwithstanding I have no thought of being vain about the importance of my own opinions. I do it merely as a right which every citizen has to repel misrepresentation of one's opinion. I shall do it with restrained feelings in respect to those who have misrepresented my position.

I do not know how important others may consider it but the fact is that had it not been for the discovery of a method of controlling the ravages of the streptococcus germ, which you have been told about today, I would have died about six years ago, and Judge Backus would have died about four years ago, and there would never have been any law firm of Corrigan & Backus. Hence, my partner and I at least owe something to the scientists who, by experimentation with animals, have developed a way of repelling the ravages of that dreadful germ, and what scientists have done for Judge Backus and me, they have done for thousands.

It is scarcely necessary for me to say that I agree that everything should be done that is reasonably necessary in order that cruelty should not be indulged against anything in the animal kingdom. I am convinced, however, that scientists have not been guilty of cruelty in their experimentation work. If any act of cruelty is committed, the present statutes are abundantly sufficient to effectually punish the wrong-doer.

I am a lawyer by profession. I do not pretend to be a scientist. I do not claim to be able to discover bugs or germs or microbes, or to sort them out or segregate them or destroy them. As a lawyer who has had an experience of considerable activity

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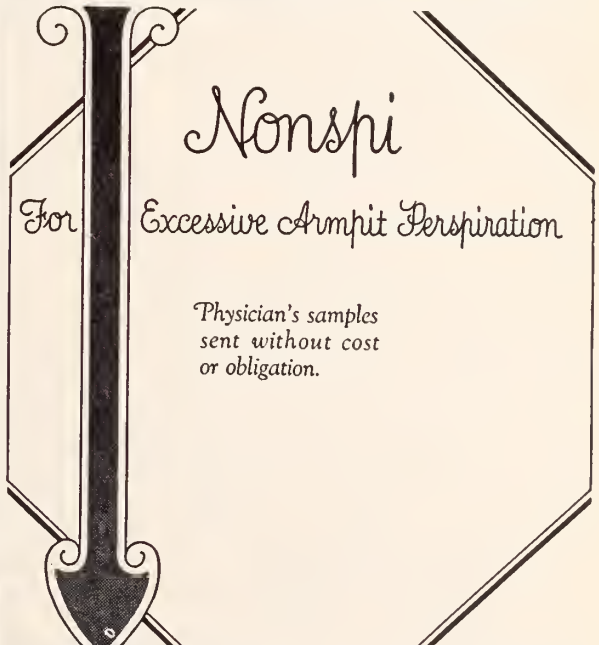

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now approaching 35 years, I have always gone to experts when I needed expert advice. When I have had sickness in my home I have gone to somebody who was trained in the science of healing. I think it is a joke for laymen to interfere with complicated scientific problems which they know nothing about. It is safe to say that there is not an acknowledged scientist in the world today that would for a single moment support this proposed measure now before you. I submit that the judgment of a multifarious aggregation of cranks should not prevail on a question of science as against the opinion of scientists.

I was very much interested today in the discussion indulged by one of the scientists concerning this dread disease of pernicious anemia. This is a disease which was incurable up to a few years ago. I had an aunt who was very dear to me and whom I loved almost as much as I do my mother. She died just a few years ago with that dread disease. This was before scientific discovery was made through experimentation upon dogs of a way to fight and cure pernicious anemia. I have at least two friends that I call to my mind today who have been attacked in recent years by that dreadful malady. Through the use of this modern treatment, rather recently discovered by the scientists through experimentation upon dogs, the lives of these friends have been saved. They are both now so restored to health that there is every promise that they will live normal lives.

The tragedy of some dreadful disease may arise in your own home any day. Suppose you had been so unfortunate as to have had a case of pernicious anemia develop upon one of your dear ones fifteen years ago? Pernicious anemia was then absolutely sure death. Today if you should have a case of pernicious anemia develop in your home these scientists as a result of their experimentation with the dog are able to save that life and yet scientific discoveries of this kind are the very things which the proponents of this bill are trying to stop.

There is nothing that we can engage in as sons and daughters of this Republic which has any nobler purpose behind it or foundation underneath it than preserving the right of every human being to live. That is the most sacred, God-given right which forms the very basis of the American Republic. The right to live is paramount and foremost in the great state papers of our history. This propaganda that is offered here would deny to the human race the right to live.

Our scientists are engaged in the great humanitarian undertaking of endeavoring to discover the cause and cure of cancer. We have great promise and hope from that which they have discovered in respect to many of the formerly incurable diseases that a cure will soon be found for that dreadful disease. Cancer is now wrecking the human race all over the face of the globe. Cancer heads the list as a cause of death in Wisconsin. Its ravages are accompanied by the most horrid pain and suffering and brings on a most horrible death.

If the proponents of this bill should have their way today it means that all experiments upon animals in an endeavor to discover a cure for cancer are to be stopped this very day. Scientific research will be stopped in its tracks. Scientists can go no further to protect the race against its invasion.

The manifest purpose of this bill is an entering wedge so that the unlearned may ultimately carry out their hobby of stopping all experimentation with animals. They admit this in their literature, though before this body they are so lacking in frankness as to base their arguments wholly upon appeals to sentiment that the dog is the equal of man.

I appreciate the time you have given me, ladies and gentlemen, and thank you for this opportunity to set myself right upon this proposition.

Mr. Crownhart: Mr. Chairman, while there are others here, they have statements here which I will file with your committee, and I call your attention to the statement of Dr. Bardeen which is given here in full, of Dr. Herwig, state toxicologist, who says he would be hampered in his work, and of Professor Tatum. We are finished, unless there are questions you would like to ask, we will close our presentation.

Chairman: Are there any questions, members of the Committee, you would like to ask the persons who have appeared here? If there are any here who would like to register here, they may give their names to the clerk.

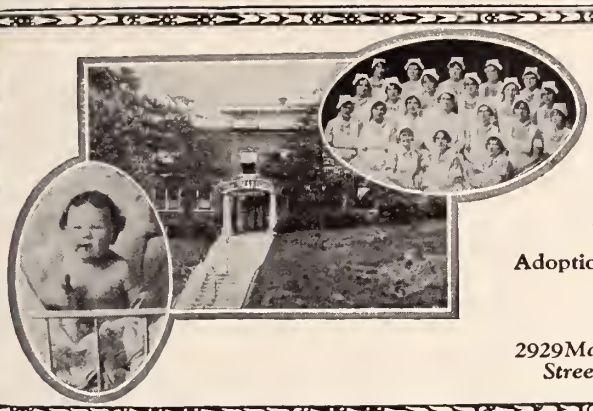
Assemblyman Kehrein (Milwaukee): I have listened here quite intently this afternoon in regard to that bill, and I want to put in my little word against this bill.

Therapeutic Notes

In addition to the articles enumerated previously, the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

I-X Barium Meal.—A mixture of barium sulphate U.S.P., 85 per cent; native aluminum silicate, 10 per cent; malted milk (malt extract-milk powder), 5 per cent; with a trace of saccharin. The preparation is used for roentgen-ray examinations, administered orally or by rectum. Dick X-Ray Co., St. Louis.

Mead's Powdered Lactic Acid Milk Noncurdling, No. 1 With Dextri-Maltose.—A modified milk product prepared by adding lactic acid, U. S. P., and a maltose-dextrin preparation to whole milk, heating, drying, and powdering. It is proposed for use in the feeding of infants when it is desired to prescribe an acidulated milk with a certain amount of added carbohydrate. Mead Johnson & Co., Evansville, Ind. (Jour. A. M. A., September 7, 1929, p. 769).



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Sobee.—A mixture of soy bean flour 67.5 per cent and barley flour 9.5 per cent, to which has been added olive oil 19.0 per cent, sodium chloride 1.3 per cent, and calcium carbonate 2.7 per cent. Sobee is used as a substitute in the diet of infants who are sensitive to the proteins of milk. Mead Johnson & Co., Evansville, Ind. (Jour. A. M. A., September 28, 1929, p. 989)

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Acne Bacillus Vaccine.—An acne bacillus vaccine (New and Nonofficial Remedies, 1929, p. 369) marketed in packages of one 5 cc. vial, and in packages of one 20 cc. vial. Hollister-Stier Laboratories, Spokane, Wash.

Pertussis Bacillus Vaccine.—A pertussis bacillus vaccine (New and Nonofficial Remedies, 1929, p. 371) composed of several strains of pertussis bacilli, marketed in packages of one 5 cc. vial, and in packages of one 20 cc. vial. Hollister-Stier Laboratories, Spokane, Wash.

Staphylococcus Vaccine (Aureus and Albus).—A staphylococcus vaccine (New and Nonofficial Remedies, 1929, p. 375) prepared from *staphylococcus aureus* and *albus* in equal proportions, and marketed in packages of one 5 cc. vial and in packages of one 20 cc. ampule. Hollister-Stier Laboratories, Spokane, Wash.

Typhoid-Paratyphoid Vaccine (Prophylactic).—A typhoid vaccine (New and Nonofficial Remedies, 1929, p. 378) consisting of a suspension of killed typhoid, paratyphoid A, and paratyphoid B bacilli. It is marketed in packages of one 5 cc. vial and in packages of one 20 cc. vial. Hollister-Stier Laboratories, Spokane, Wash. (Jour. A. M. A., October 5, 1929, p. 1065)

Atoquinol Ciba.—The allyl ester of 2-phenyl-quinalin-4-carboxylic acid. The actions and uses of Atoquinol-Ciba are practically like those of cinchophen. It is supplied in the form of tablets 0.25 Gm. (4 grains). Ciba Co., Inc., New York. (Jour. A. M. A., October 19, 1929, p. 1223)

Chiniofon. — Sodium - iodoxyquinolinesulphonate. —A mixture prepared from approximately four parts of 7-iodo-8-hydroxyquinoline-5-sulphonic acid, containing not less than 26.5 per cent of combined iodine, and 1 part of sodium bicarbonate. Chiniofon, which is closely similar to preparations introduced under various proprietary names as wound antiseptics, has been found to be of use in the treatment of amebic dysentery.

State Board of Health Proposes Four Bills in Legislature

Amendment of Wisconsin statutes relating to county health administration will comprise most of the legislation sponsored in the present legislature by the State Board of Health.

Under the enabling act created by the last legislature for the establishment of county health units employing a full-time health officer, no provision was made for the continuance of health departments of cities desiring to join the county organization. (Reference, Section 140.09, Wis. Statutes.)

An amendment to this law will be introduced, whereby such a city may join the county unit without giving up its nurses, inspectors or laboratories.

Under the terms of an amendment to Sec. 141.06, a physician appointed by the county board of supervisors from a list of three candidates submitted by the County Medical Society would be a member of the county health committee, the other members of the body being the chairman of the county board, not less than two members of the county board, a woman appointed by the county board, and the deputy state health officer, ex officio.

Revision of the duties of county nurses, based upon the increased specialization of public health work since the adoption of the original bill in 1913 is included in the proposed legislation that the State Board will sponsor during the present term.

An amendment to Sec. 140.07, which would remove the present limitation of $3,000 as the maximum annual salary of deputy state health officers, completes the legislation that will be sponsored by the State Board of Health.

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Courses in Nursing Courses in nursing are offered in the School of Nursing affiliated with the medical school. A residential course of 32 months is offered in the Wisconsin General Hospital to those who have completed a semester of specified work in the College of Letters and Science. This course leads to a certificate of graduate nurse. A residential course of 27 months is offered to those who have completed three years of college work in specified subjects either in the College of Letters and Science or in the Department of Home Economics. These courses lead to a certificate of graduate nurse and to a B. S. degree.

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APPROPRIATIONS CONTINUED

Activities of the State Board of Health, as carried on during the past biennium, will not be materially altered under the terms of the new budget as adjusted by the budget bureau and now in the hands of the joint finance committee.

Nine former funds among those by which the State Board of Health is financed will be merged into a general administration fund under the current budget, comprising the state laboratories, silver nitrate, social hygiene, sanitary engineering, stream pollution, communicable diseases, rest rooms and comfort stations, and Indian funds.

Hearing on the new budget was conducted Tuesday, Feb. 3, by the joint finance committee, at which no opposition to the terms of the financial plan was indicated.

Recent Licentiates in Wisconsin

BY EXAMINATION

Name	School of Graduation	Year	Present Address
Dodson, Charles A., M. D.	Marquette Medical Sch.	1930	Palmyra, Wis.
Drischel, Frank G., M. D.	Northwestern Medical Sch.	1927	Wis. Gen. Hosp. Madison, Wis.
Hameister, Nellie C., M. D.	Barnes Medical Sch.	1909	State School, Sparta, Wis.
Noonan, John F., M. D.	Queens Medical Sch.	1924	Wis. State Hosp. Mendota, Wis.
Rau, Gerald Albert, M. D.	Wis. U. Sch. of Med.	1928	411 Garfield Ave. Chicago, Illinois
Stadel, Ernest Vernon, M. D.	Wis. U. Sch. of Med.	1928	Wis. Gen. Hosp. Madison, Wis.
West, Elden Dean, D. O.	Des Moines Still. Col. of Osteo.	1931	856–16th St., Des Moines, Ia.
Gascoigne, Clarence C., M. D.	Marquette Med. Sch.	1930	5808–22nd Ave. Kenosha, Wis.
O'Brien, George M., M.D.	Marquette Med. Sch.	1930	1229 Rawson Ave. Milwaukee, Wis.
Purtell, Paul Jos., M. D.	Marquette Med. Sch.	1930	571 Summit Ave. Milwaukee, Wis.

BY RECIPROCITY

Altman, James Sloan, M. D.	U. of Ill. Med. Sch.		Mazomanie, Wis.
Blankinship, Rex, M. D.	U. of Virginia Med. Sch.	1929	Wis. Gen. Hosp. Madison, Wis.
Brindley, Benj. I., M. D.	Rush Medical College	1929	Wis. Gen. Hosp. Madison, Wis.
Caldwell, Ruth, M. D.	U. of Wis. Med. Sch.	1929	Wis. Gen. Hosp. Madison, Wis.
Drew, Frank E., M. D.	U. of Ill. Med. Sch.	1930	1056 Lexington Blvd. Milwaukee, Wis.
Eischeid, Rudolph J., M. D.	Chi. Col of Med. & Sur.	1913	New Albin, Iowa
Farnsworth, Richard W., M. D.	Harvard Medical Sch.	1928	205 S. 3rd St., Janesville, Wis.
FitzGibbon, Thomas, M. D.	Creighton Med. Sch.	1924	1309 Wells Bldg. Milwaukee, Wis.
Harris, Mayo A., M. D.	Meharry Med. Sch.	1921	1010½ City Park Ave. Toledo, Ohio
John, Geo. W., M. D.	Northwestern Med. Sch.	1927	405 E. Grand Ave. Beloit, Wis.
Langen, Paul C., M. D.	Jefferson Med. Col.	1921	3000 No. Frederick Ave. Milwaukee, Wis.
McGonigle, Bartholomew, M. D.	Loyola Med. Sch.	1929	Ableman, Wis.
McLaughlin, Alan F., M. D.	U. of Ill. Med. Sch.	1930	Richmond, Ill.
Michel, Henry H., M. D.	U. of Minn. Med. Sch.	1930	Grantsburg, Wis.
Rastello, Peter, M. D.	U. of Mich. Med. Sch.	1927	1229 Blaine Janesville, Wis.
Ricketts, Floyd B., M. D.	Nat'l. U. of Arts & Science	1915	303 N. 76th St. Milwaukee, Wis.
Smith, Leonard M., M. D.	Northwestern Med. Sch.	1926	174 Washington Blvd. Oshkosh, Wis.
Smith, Wm. M., M. D.	Northwestern Med. Sch.	1926	569 Algoma Blvd. Oshkosh, Wis.
Rydell, Wm. Birger, M. D.	Harvard Medical Sch.	1929	Buffalo, Minn.
Schneck, Nathan, M. D.	St. Louis Sch. of Med.	1923	3201 W. Roosevelt Rd. Chicago, Illinois
Sproul, Wm. Mathew, M. D.	U. of Iowa Med. Sch.	1926	% Milwaukee Sanitarium Wauwatosa, Wisconsin
Steinkopff, Edward K., M. D.	U. of Ill. Med. Sch.	1929	Statesan, Wis.

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NUMBER 5

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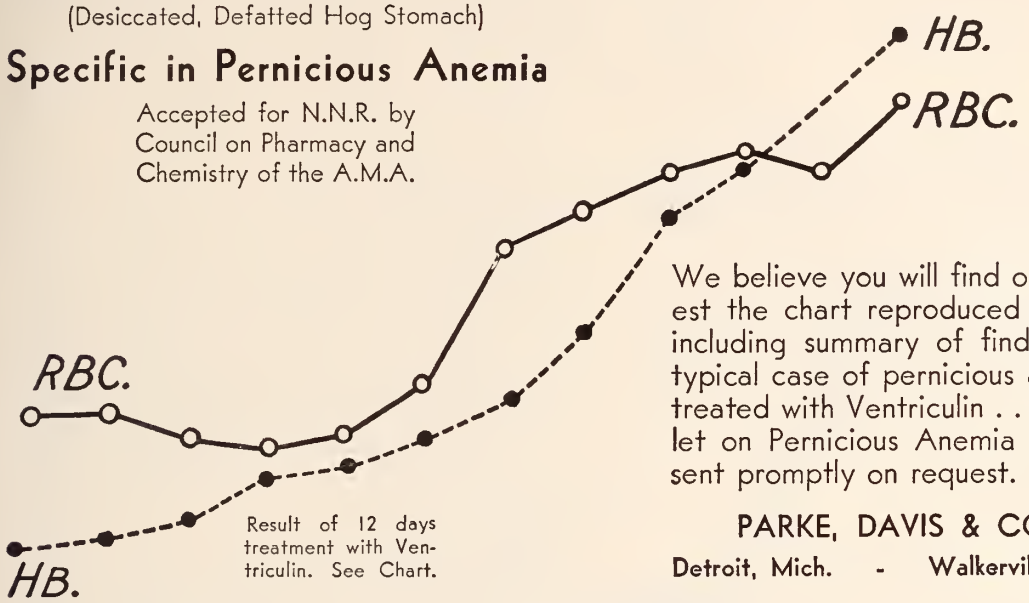

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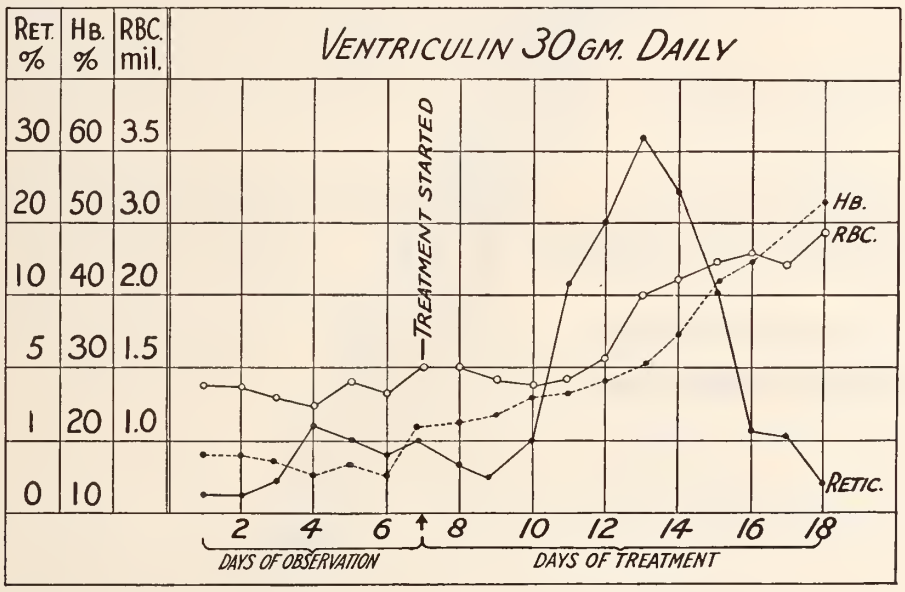

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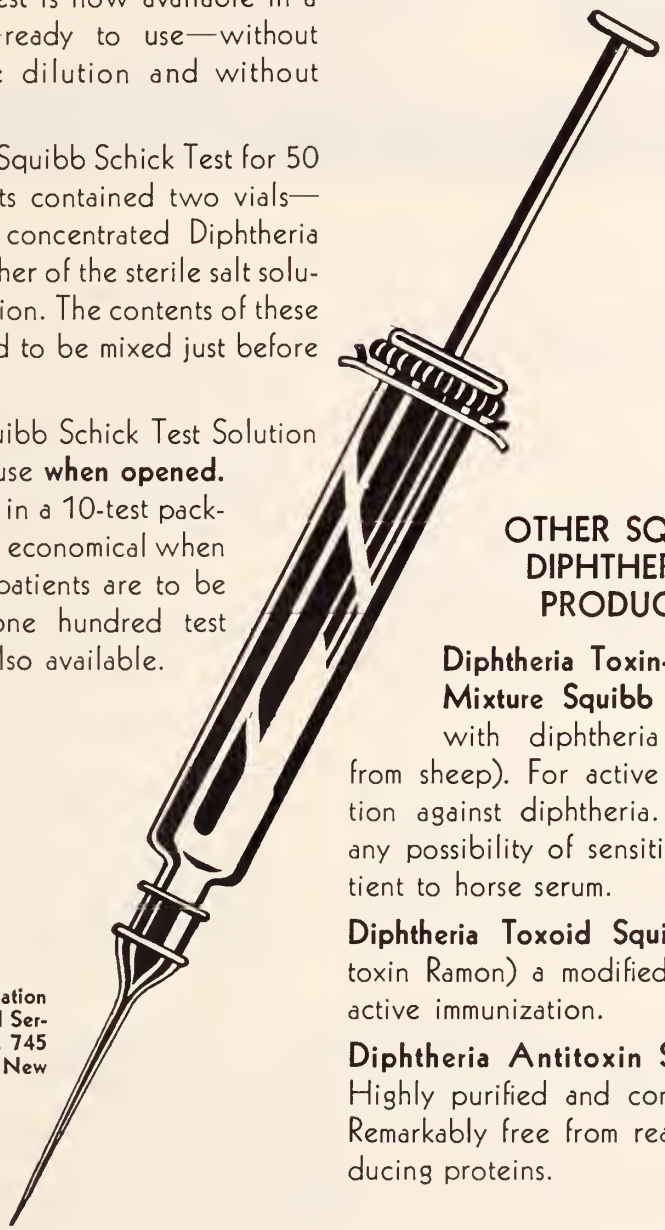

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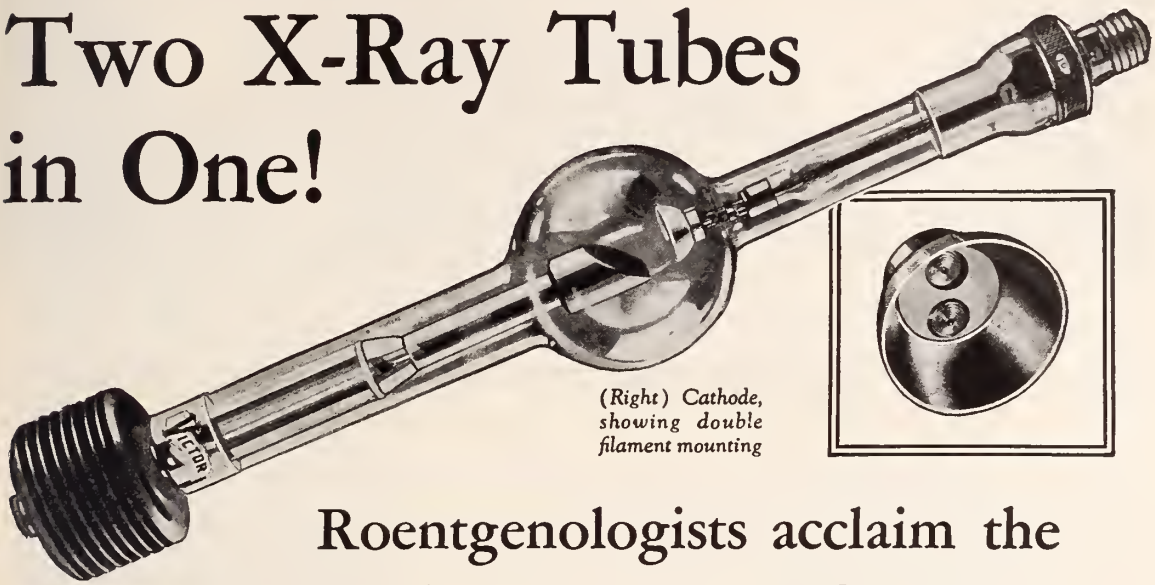

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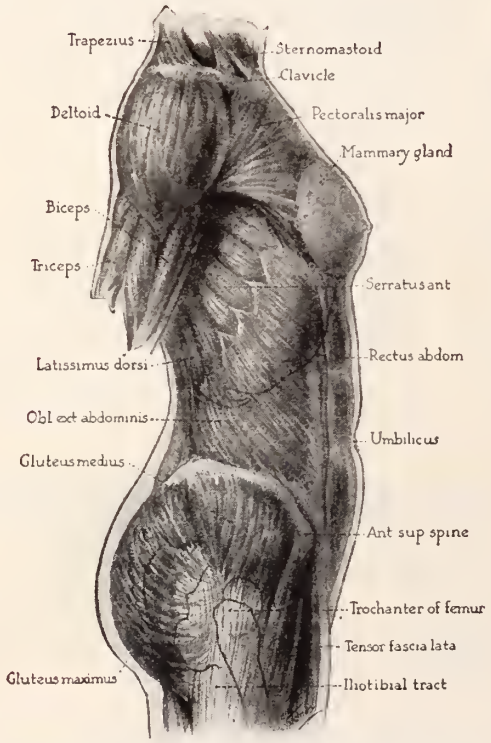

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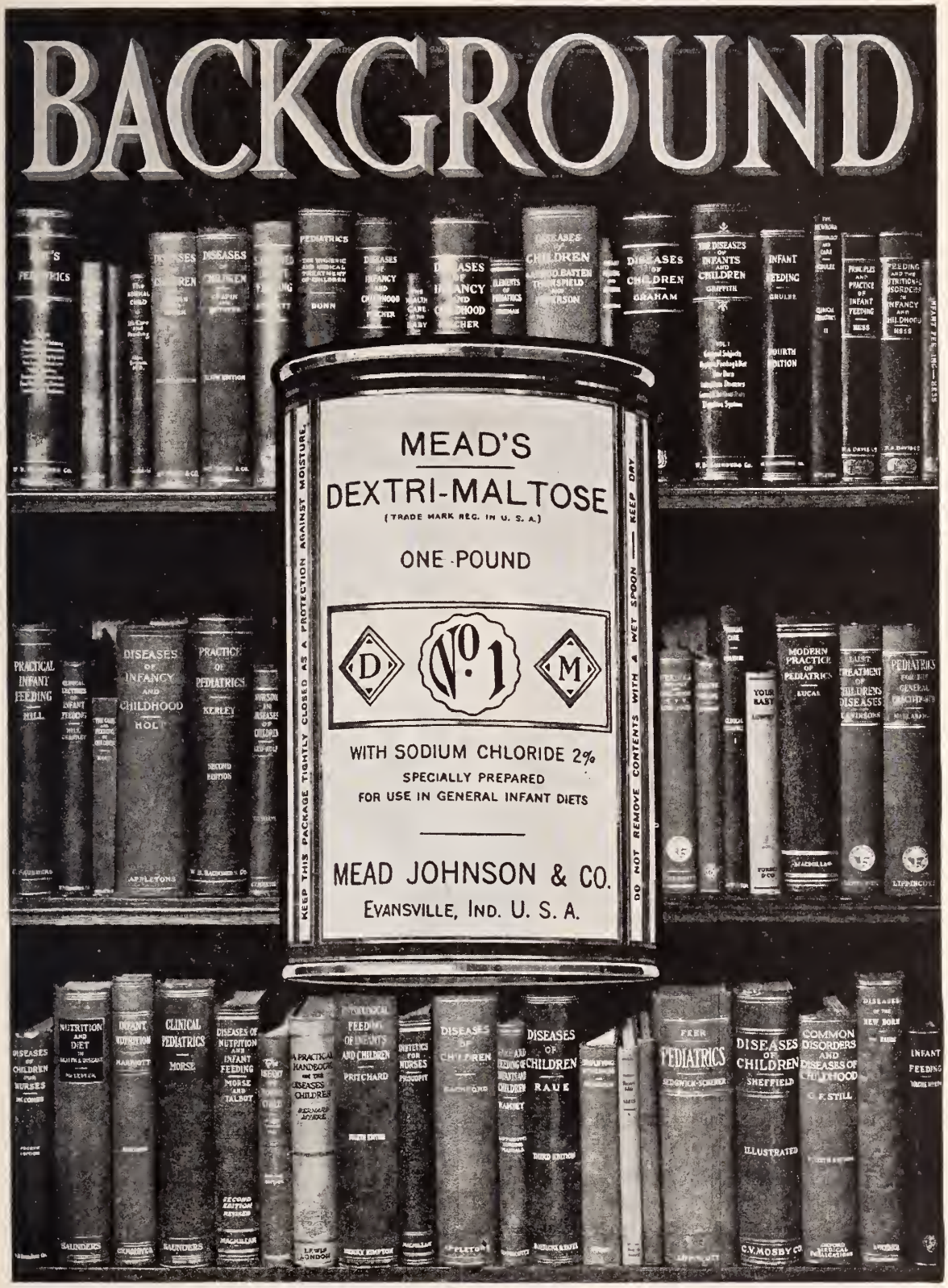

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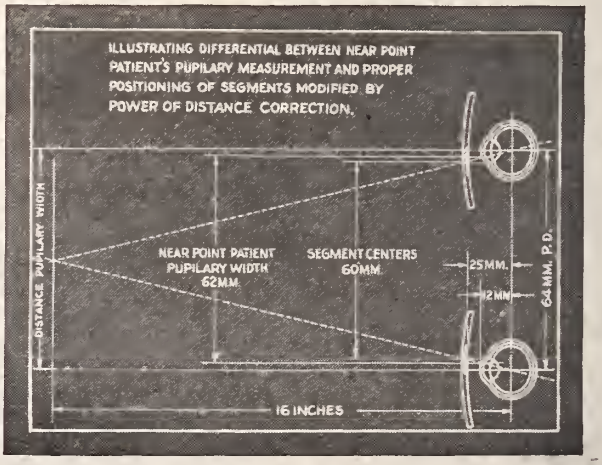

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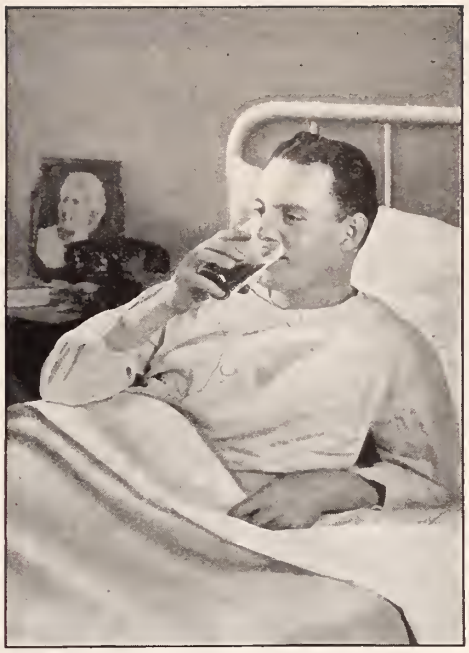

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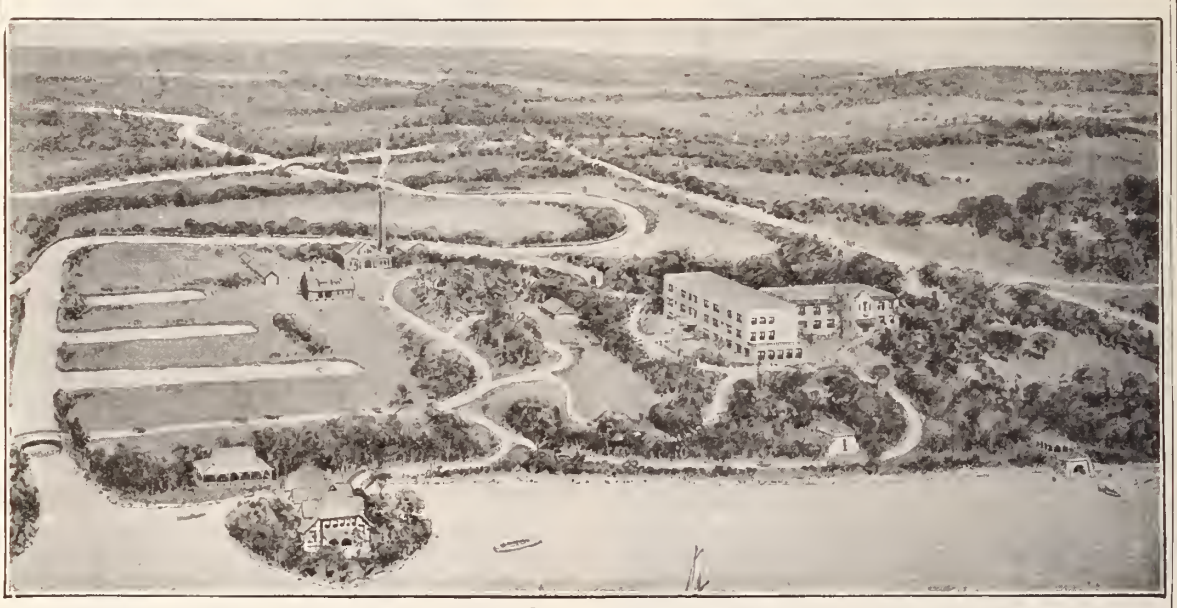

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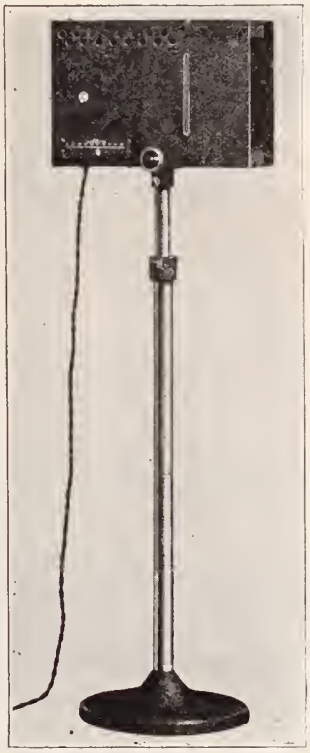

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The Wisconsin Medical Journal

Volume XXX MADISON, WIS., MAY, 1931 No. 5

Hyperinsulinism; With Report of Case*

By HAROLD E. MARSH, M. D.
Jackson Clinic, Madison

A discovery pertaining to one disease is often the means of indirectly revealing facts relative to allied or unallied conditions. The symptoms in certain non-diabetic individuals, who presented a hypoglycemia so closely simulated to those arising from an insulin reaction in diabetic persons, led Harris, in 1924, to suspect that in such persons a condition of hyperinsulinism existed.

Substantiation of this view was furnished by proof from the Mayo Clinic in a case of hypoglycemia occurring in a man who had carcinoma of the islands of the pancreas. Since then other cases of tumors of the pancreas, both benign and malignant, associated with hypoglycemia have been reported. Cases corresponding with these clinically, with the same degrees of hypoglycemia, have been seen in which the pancreas was normal. In the case from the Mayo Clinic, metastases of the pancreatic carcinoma occurred in the liver. An extract of the metastatic carcinoma showed insulin activity.

Insulin was recovered from a tumor of the pancreas in a patient of Howland, Campbell, Maltby and Robinson. This patient had the characteristic symptoms and low blood sugar of hyperinsulinism. It would seem that the carcinoma cells of an islet carcinoma have the same ability to secrete insulin as the normal island cells.

All tumors of the pancreas do not cause hyperinsulinism. The cases of adenomas of the pancreas with and without evidence of hyperinsulinism are comparable to adenomas of the thyroid with and without hyperthyroidism.

Proof has been shown that the secretion of the normal pancreas is regulated by the need for it, and a considerable amount of evidence suggests that such regulation is at least in part neurogenic. Whether functional neurogenic or endocrine unbalance is a factor, in those cases of hyperinsulinism without pathologic changes in the pancreas, remains to be determined.

Hypoglycemia may be of pancreatic or hepatic origin. In the pancreatogenic type this is due to an overfunction of the pancreas; in the hepatogenic type to failure of the liver to supply sugar to the blood.

Complete removal of the liver, as Mann has demonstrated, is followed by the characteristic symptoms of a progressive and fatal hypoglycemia. He found, however, only slight changes in the blood sugar level after partial removal of the liver in dogs, resulting in a permanent reduction of hepatic tissue in some instances to less than 15 per cent.

It is very rare to find clinical or laboratory evidence of hypoglycemia in hepatic disease. It may occur in advanced cirrhosis, yellow atrophy, or in extensive tumors of the liver.

Nadler and Wolfer have reported a case of carcinoma of the liver which replaced 70 to 80 per cent of liver substance. Attacks of unconsciousness with low blood sugar levels had occurred, the low level of 13 mgs. was reached two hours before death. Epinephrin failed to produce a rise in blood sugar.

In view of Mann's results, their conclusions were that although the quantitative decrease in liver substance of 70 to 80 per cent was an important factor, a functional deficiency was also associated with an inadequate store of glycogen in the remaining cells. As the tumor contained no insulin, they concluded that the hypoglycemia was hepatogenic due to hypofunction of the residual cells.

It is interesting to note in this case that in spite of the extensive infiltration of the liver by carcinoma, the van den Bergh and bromsulphthalein tests were negative.

* Presented before the 89th Anniversary Meeting, State Medical Society of Wisconsin, Milwaukee, September, 1930.

Although direct evidence of hepatic dysfunction is not present in most cases of spontaneous hypoglycemia, we have no suitable method of determining the functional capacity of the liver relative to carbohydrate metabolism.

Solutions of epinephrin and pituitary extract in the presence of a normal liver cause a mobilization of glycogen with a corresponding rise in blood sugar. The blood sugar of dehepatized animals is unaffected by these solutions. The rise in blood sugar content following the administration of these agents in a given case might, therefore, be taken as evidence that the hypoglycemia was not due to loss of hepatic function; the converse, however, would not necessarily be true.

The severity of the symptoms of an insulin reaction varies in direct proportion to the fall in blood sugar. This is true in hyperinsulinism. There is, of course, an individual variation in both instances, symptoms of a certain severity occurring in one with the blood sugar at a higher level than in another.

In the organic and functional types of hyperinsulinism, symptoms may be mild or very severe. In the former they are more liable to be severe, while in the latter there is a greater percentage of mild cases, although severe manifestations are frequently seen.

The mild types associated with only a moderate hypoglycemia are most difficult to recognize, unless the condition is kept in mind. Weakness is the most prominent feature; this usually, though not always, occurs several hours after meals and frequently necessitates rest. Associated with the weakness there is nervousness and a sensation of inward trembling. The hunger which occurs produces a desire to eat. Shortly after food is taken the symptoms disappear and former activities can be resumed.

In addition to the preceding symptoms, in slightly more marked instances, sweating with actual tremors, palpitation and a feeling of faintness and dyspnea are experienced. Tachycardia is present.

When such symptoms are accompanied by hypoglycemia and are relieved by eating, the diagnosis of neurasthenia, which previously has been made, would not be justifiable. Before the recognition of hyperthyroidism, the nervous manifestations of this condition often were attributed to neurosis. Mental convulsive seizures simulating epilepsy, and confusion, disorientation, incoordination, coma are characteristic of the most severe form.

Nielson and Eggleston have recently reported three cases of "epilepsy" due to dysinsulinism and hyposuprarenalism. Following the institution of frequent feedings and suprarenal extract, there was a complete cessation of attacks of unconsciousness. In one case more than 100 complete seizures had occurred with many petit mal attacks, yet all attacks ceased under this treatment. Six cases of idiopathic epilepsy were treated with frequent feedings and suparenal extract by mouth. No results were obtained.

Therefore, we are now able to remove from those large groups of patients with neurasthenia, hysteria, and epilepsy, certain individuals who show the characteristic hypoglycemia which can be controlled by the ingestion of carbohydrates. More and more of these hitherto unfortunates will be recognized by the more frequent taking of blood sugar determinations and placed in their proper position in life.

The chart shows that the fasting blood sugar is not always an index of a patient's low point. In only two of the nine cases was it lower than the blood sugar taken two and three hours after the ingestion of glucose.

Date	Before Glucose	½ hr.	1 hr.	2 hrs.	3 hrs.
4:30:30 Mr. B. T.	80	88	101	71	51
5:5:30 Mr. R.J.O.	63	99	106	71	50
5:15:30 Mrs. H.F.	83	153	142	75	68
8:23:30 Mrs. W.L.	74	113	93	71	69
7:29:30 Mrs. R.L.	60	79	84	84	71
9:8:30	80	156	93	82	82
8:26:30 Mrs.L.McK	76	95	100	110	60
9:3:30	66	80	88	75	57
8:8:30 Mrs.N.U.	53	127	107	90	75
9:2:30	71.1	101	88	77	63
7:31:30 Mrs.J.J.C.	62.8	93.8	57.3	55.6	50.2
8:7:30	69	135	93	83	54
8:30:30	61	100	58	60	45

The secretion of the normal pancreas is regulated by the need for it. Low fasting blood sugars would seem to show that small amounts were being liberated continuously (dysinsulinism) whether the blood sugar

was high or low, that is, irrespective of the requirements.

The rapid fall in blood sugar, two and three hours after the taking of glucose to points below the fasting level, would seem to indicate an abnormal insulin response on the part of the pancreas with a production greater than the need.

In none of the seven cases, in which urine-sugar examinations were made at the time each specimen of blood was taken during the glucose tolerance test, was sugar found. This would indicate that there were no cases of potential diabetes.

TREATMENT

In the relatively mild cases, frequent carbohydrate feedings will suffice to control the hypoglycemic tendency. This frequency must be adapted to the individual case and will depend upon its severity. Six meals a day may afford an adequate carbohydrate supply, in other instances feedings every two hours during the day with several feedings at night may be necessary.

Nielson and Eggleston, because of their experience with suprarenal gland by mouth in raising the blood pressure in cases of hypotension, decided that if the blood pressure could be maintained at a higher level by the substance, perhaps the blood sugar could be similarly maintained. They conclude as a result of their observations that frequent feeding alone may suffice in these cases to prevent epileptiform seizures, but frequent feeding plus suprarenal gland by mouth is a surer manner of maintaining sufficient blood sugar to prevent attacks.

The severe forms of hyperinsulinism may fail to respond completely to the frequent ingestion of food. The symptoms may be such that work is impossible. The necessity of eating at intervals during the night seriously interferes with sleep. The demonstration of the origin of hypoglycemia in a case of a tumor of the pancreas aroused the hope that the situation might be remedied by surgical intervention. The possibility of curing hyperinsulinism by removal of a pancreatic tumor or resection of a part of the pancreas is suggested by the analogy of the condition to hyperthyroidism.

Five cases have been reported in which operations upon the pancreas have been performed. In four cases, two from the Mayo Clinic, one reported by Finney and Finney, and one operated on by Holman, the pancreas at operation was found to be normal. Partial resection of the pancreas in these cases failed to relieve completely the hypoglycemic tendency. In the fifth case reported by Howland, Campbell, Maltby and Robinson, a tumor 1.5 cm. in diameter was found at operation in the middle of the body of the pancreas. The tumor possessed certain features of a malignant growth. Following operation the blood sugar remained normal and the hypoglycemic symptoms did not recur.

Hope of control of the disorder by surgical measures in such cases lies in more radical resections.

CASE REPORTS

Case I

Woman, aged 43.

Past History: Resection of right ovary 1910. Resection of left ovary, 1918.

Present Illness: She has been nervous since her last operation. During the past few months, she has had attacks when she became very weak and trembling. These spells occurred an hour or two before meals. She found that the attacks could be prevented by eating.

Physical examination was negative. Blood pressure 142/90.

Glucose tolerance test, see chart.

Marked improvement followed treatment which consisted of one lunch in the forenoon, two in the afternoon and one at bedtime. Even though her symptoms were kept in abeyance by frequent feedings, the low point in her glucose tolerance test was lower after treatment than before.

Case II

Man, aged 31.

Past History: Appendectomy, 1913.

Present Illness: For two or three years he has felt tired and weak, especially in the morning on dressing. In the past few months he has awakened several times at night with a smothering sensation and trembling. For several weeks these same sensations occurred during the day, especially the latter part of the forenoon. He felt weak, shaky and dyspneic, his heart seemed to pound and he broke out in cold perspiration. During one attack, he lost consciousness for several minutes.

Physical examination revealed nothing of consequence. Blood pressure 106/74.

Glucose tolerance test, see chart.

Treatment: He was advised to eat six meals a day.

Following this, his attacks subsided.

Case III

Woman, aged 24.

Past History: Appendectomy, 1928.

Present Illness: For the past four years she had been having attacks of vertigo at varying intervals. During the past three weeks attacks of weakness occurred. At such times she felt that she was on the verge of fainting, but had never lost consciousness.

Physical examination was negative except for a retroversion of the uterus.

Glucose tolerance test: See chart.

Treatment: High carbohydrate diet with frequent feedings. The dizziness entirely disappeared, the weak spells became much milder, occurred less frequently and were quickly controlled by eating.

Case IV

Woman, aged 32.

Past History: Appendectomy, 1919.

Present Illness: For the past two years she has complained of feeling tired; no ambition. She took injections of iron for a year without improvement. For several months she had attacks when she felt very weak and nervous and had a tight throbbing feeling in her neck. There had been a loss of 15 lbs. in weight in four months.

Physical examination negative. Blood pressure 120/70.

Glucose tolerance test: See chart.

Treatment: High carbohydrate diet. Frequent feedings. Four months later she stated in a letter that she was feeling very much better. The weak spells, with throbbing in her neck, occurred occasionally but only after unusual exertion.

Case V

Woman, aged 28.

Past History: Appendectomy 1919. Thyroidectomy for non-toxic adenoma of the thyroid, 1927. Four months previously, she had started on a reducing diet, eating very little carbohydrate foods.

For two or three months she had been having attacks consisting of weakness, nervousness, crying and difficult breathing. These attacks most commonly occurred between two and three hours after breakfast. During the attacks she felt quite hungry and found that by eating something she would feel better.

Physical Examination: Negative. Blood pressure 114/78.

Glucose tolerance test: See Chart.

Treatment: High carbohydrate diet; frequent feedings.

Attack subsided except one morning she omitted lunch at time she had an attack.

Case VI

Woman, aged 57.

Past History: Unimportant.

Present Illness: For six months she had been troubled with a rapid heart with sharp pains at the apical region. For two months she had felt weak. Whenever her stomach became empty she would have attacks of weakness, faintness and would feel shaky. These symptoms would last until she ate something. There had been considerable flatulency at times.

Physical Examination: Negative except for mitral regurgitation.

Glucose tolerance test: See chart.

Treatment: High carbohydrate diet; frequent feedings.

Case VII

Woman, aged 26.

Past History: Appendectomy 1923. Tonsillectomy.

Present Illness: During the past six months she had been having attacks of weakness, dizziness and trembling with partial loss of consciousness. She was completely unconscious in three attacks. When unconscious, she would breathe rapidly, her heart was fast and her face flushed. There were no convulsive seizures. These attacks were most liable to occur several hours after a meal.

Physical Examination: Essentially negative. Blood pressure 120/70.

Glucose tolerance test: See chart.

Treatment: Six meals a day.

No further attacks occurred, one month after instituting treatment. One morning she omitted her forenoon lunch and about eleven o'clock she began to feel week and shaky. As soon as she ate, these symptoms immediately disappeared.

Case VIII

Man, aged 36.

Past History: Negative.

Present Illness: For a period of a year he had been unable to have a bowel movement without an enema. He had, as he described it, felt "all in" for several months with frequent attacks of weakness, palpitation and dyspnea.

Physical Examination: negative. Blood pressure 130/80.

Glucose tolerance test: See chart.

Treatment: Six meals a day controlled his attacks.

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DISCUSSION

Dr. F. J. Hirschboeck (Duluth):

There is one phase I would discuss—the breathing. The breathing is not so much of the smothering as the shallow type. The thought occurred to me that it may be the antithesis of the breathing in patients with a diabetic condition and who are in a condition of acidosis Kussmaul breathing.

One other point about this condition is the fact that it may at times lead to confusion in the diagnosis of duodenal ulcer. The patient may have sensations in the abdomen occurring two or three hours after meals that may be confused with symptoms of duodenal ulcer. The therapeutic test, x-ray, plus the blood sugar findings, will elucidate the true condition.

Hypothyroidism*

By R. M. KURTEN, M. D.
Racine

Hypothyroidism of the so-called mild or masked type is not in any sense a new disease, but is not recognized as frequently as it should be. This subject has interested the writer chiefly because of the satisfactory results obtained through adequate treatment. The disease entity "mild hypothyroidism" has not become a fixture in the diagnostic sphere of many of the profession who must encounter such cases in daily practice. Early recognition and treatment of the condition will remove many cases from the group of neurasthenics, sufferers from auto-intoxication, myasthenia, constitutional inferiority and the menopausal sufferers and restore them to their natural and normal place in society.

Hypothyroidism of the mild form is a disease characterized by chronic fatigue, lassitude, chilliness, dryness of the skin and hair, decreased or absent perspiration, and usually, but not necessarily increased weight, and menopausal disturbances in the female. There is also a protean group of additional or subsequential disorders as vague pains, loss of hair, fat deposits in the supraclavicular fossae, secondary anaemia, cold extremities, low blood pressure, and so on.

ETIOLOGY

The geographical distribution is universal but of more frequent occurrence in goiter regions.

The true etiological factors in thyroid disturbances are not definitely known. The work of McCarrisòn & Marinne has brought forth many suggestive factors, but none other than iodine deficiency has been definitely proven and accepted.

Heredity is concerned as shown by series wherein cretinism, childhood myxoedema and adult myxoedema have resulted in the offspring of parents where thyroid insufficiencies have been present. Sloan discussed the role of the thyroid in differential development, and laid at the doorstep of thyroid insufficiency much of the abnormal development of children and young adults as cretins, cretinoids, the misshapen and deformed, deaf mutes, degenerates and criminals showing mentality and physique leading to considerable subnormality. He does not say that the thyroid is deficient in the offspring. The direct cause of the many sociological and mental behavioristic dedefects, he believes, are due to lack of differential development in the offspring as a result of deficiency in the mother.

Pregnancies, especially frequent ones or repeatedly interrupted ones, plus infections of a mild degree following abortions, stand out rather prominently as an etiological factor.

Infections, such as measles, flu, enteritis, and colitis are frequently mentioned. Focal infection, as of teeth, tonsils, gall bladder, appendix, etc., may also strike the thyroid

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an overwhelming blow and disturb its equilibrium to such a degree that it is unable to cope with the physiological demands.

Toxemias, especially lead and alcoholic, are mentioned. Under-nourishment and faulty nutrition are prominently mentioned by Marinne and McCarrison, the two most prominent factors in these cases being absence of adequate amount of iodine in food and water, and high protein diets.

Psychic states, such as anxiety, grief, and mental strain are also cited as predisposing factors. Age, puberty and menopause, are periods of thyroid hazards, as pointed out by O'Keefe and others, in producing thyroid fatigue and deficiency of function. The persistence of colloid goiter of adolescence leads to the hypothyroid state. During menopause, the dying ovary, in cases where the gland chain equilibrium is weakened, is the impetus which completely deranges the balance and is said to be a powerful factor in producing thyroid disturbances, a stormy menopause results, ranging from severe nervousness to insanity. O'Keefe theorizes to the effect that if normal glandular equilibrium exists previous to menopause the endocrine hormones are able to bridge the gradual break and adjust themselves. Undoubtedly endocrine function does not play as important a part after monopause as it does preceding it. In a pre-existing hypothyroidism, the thyroid is unable to stand the additional strain and the already damaged gland is aggravated beyond control, severe menopausal reaction resulting.

Thyroiditis is considered a factor by Kauffman, Marinne and others. Trauma and surgery diminishing the functioning gland to below normal, the requirement, causing cessation of function, will lead to hyperthyroid state of a mild variety. The sex ratio is given as four to one by some; seven to one by others.

PATHOLOGY

Briefly, thyroxin, as isolated by Kendall from the colloid of thyroid follicles in 1915 and synthesized by Harrington in 1927, is the active hormone of the thyroid gland. The mode of action of thyroxin is not definitely established. The most likely theory is that of cell stimulation brought about indirectly by thyroxin acting on the visceral or autonomic nervous system, and principally, if not entirely, on the sympathetic system according to Marinne. The chief function of the thyroid, through its hormone thyroxin, is to provide a means for maintaining a higher rate of metabolism than would exist without it, and through fluctuations of its activity a means is provided for changing the metabolic rate to meet changing physiological demands.

The thyroid is subject to the same basic pathological processes as are common to all body tissues, differing only in its ability for growth and involution. The most important of these changes, as shown by Marinne, are those occurring in goiter; namely, the changes corresponding to the physiological cycle of the thyroid cell, hypertrophy, hyperplasia, and involution or atrophy in various degrees. This cycle of morphological changes may be repeated once or many times during the life of the individual; each succeeding cycle more greatly distorting thyroid morphology by fibrosis and vascular changes plus the various degenerations. Wherever the store of iodine falls below the normal minimum, the blood supply of the gland increases, colloid is decreased, and the process of changing from low cubical epithelium to cubical and finally columnar, begins. If physiological demands are not then satisfied it extends to hyperplasia of both mild and extreme degrees. As the demand is compensated, involution sets in, and physiological recovery is effected, the so-called colloid goiter. This latter process may be greatly hastened by iodine feeding according to Marinne. In any gland thus forced through a cycle of increased physiological demands, and especially in regions of endemic goiter, compensation fails, and sooner or later a state of thyroid exhaustion supervenes; this is germane to the subject under discussion.

There are all degrees of exhaustive hypertrophy, the most extreme being scirrhous atrophy, wherein the follicles are compressed or atrophied to occasional irregular cell rests scattered through the stroma. According to Oswald, colloid goiter is, in di-

rect opposition to Basedaus goiter, accompanied by hypothyroidism. There is a secondary morphological feature of goiter which *is* interesting, namely, adenomatous nodules. The accepted thought at present seems to be that these nodules are the result of different degrees of hypertrophy and hyperplasia in the gland in long standing goiters due to pressure of stroma bands, or colloidal retention cysts, with subsequent hemorrhages, or various degenerative changes. These injuries produce patchy hyperplasia in glands having undergone several cycles of hyperplasia and involution. These adenomata have a morphological cycle similar to non-adenomatous goiters and may go on to exhaustive atrophy. Adenomatous goiters are therefore consistent with the occurrence of hypothyroid states of any degree.

Dequervain and his pupils frequently observe non-suppurative inflammations, thyroiditis simplex, especially in chronic pulmonary tuberculosis. The iodine content decreases and this may lead to hypothyroidism.

Rieman calls attention to the difference in response of the thyroid in goiterous and non-goiterous regions and emphasizes its response at puberty, during menstruation, in pregnancy, and menopause. Seasonal variations in activity, variations in activity as a result of temperamental responses, are probably reflected in its later appearance and function. He emphasizes that hyperplasia and hypertrophy continue in response to the above mentioned demands until the gland is "worn out", whereupon atrophy supervenes.

Metabolic disturbances are pronounced, and give us very important information both diagnostic and in control therapy. The gaseous exchange is diminished as first shown by Mangus Levy, who also showed that adequate therapy caused its return to normal limits. This method was long lost sight of and clinical applications not made until the comparatively recent studies of Dubois, Plummer, Means and Aub. The rate in myxoedema is in the neighborhood of minus forty; in masked hypothyroid states from minus ten to minus thirty are obtained, although readings to plus ten may be obtained during pregnancy and complicating factors as pituitary insufficiencies.

The quantity of urine is lessened, as is also the output of nitrogenous products. Carbohydrate metabolism is normally influenced to considerable extent, and increased sugar tolerance is the rule. Hypoglycemia was demonstrated by Janney, Isaacson and J. Watson Campbell in analyzing the hypothyroid cases that presented themselves at the Halstead Clinic where they found low fasting blood sugar and a high tolerance for sugar with the absence of sugar in the urine in all cases.

Fat metabolism. As in many other endocrine dystrophies, obesity of an endogenous nature occurs. This manifestation comes on early and is persistent. We should bear in mind that the thyroid gland functions normally to maintain cellular nutrition and growth, and that in hypothyroidism these processes are inhibited, the gaseous exchange lowered, and excretion of protein metabolites diminished; repair is at its lowest ebb and glucose tolerance is increased. The adiposity of hypothyroidism is possibly due to the diversion of carbohydrates into fatty tissue through synthesis which normally would be anabolized into protoplasmic elements or burned as fuel. Briefly, the same kind and quality of food fed to two different individuals provides two different values of energy. We know that two cars built on a chain will produce varying amounts of speed and power on the same fuel, depending on the ignition, carburetion, etc. So, food has different dynamic values in different individuals, depending largely on their endocrine, especially thyroid, activities.

SYMPTOMATOLOGY

There are certain symptoms which are always present, and others which are present in one case, are absent in another. The patients usually present themselves complaining of chronic fatigue, being chilly or cold when other people are comfortable, vague pains and lassitude. Gain in weight is usual but not necessarily present, some of the writer's most pronounced cases being decidedly under-nourished and below weight.

This is an important point, inasmuch as hypothyroid states are usually associated only with obesity. On questioning, nervousness is invariably present, not the excitable type found in hyperthyroidism, but the depressed, irritable, melancholy type, "has the blues", feel sorry for themselves, and have a good cry several times a day. Paresthesia, a creeping sensation over the back, neck, and arms is found. One of the author's patients has a creeping tumor in her abdominal wall, which disappears, but recurs in her periodic lapses of treatment. A sense of choking, or fullness in the neck when excited, a rather typical globus hystericus picture, and difficulty in swallowing are frequently complained of. Heart trouble is a frequent complaint, which on analysis usually turns out to be gaseous distention of the stomach. Air swallowing is probably initiated by the fear of choking previously described, and continued to the stage of habit formation.

From the work of Fahr we must consider real cardiac decompensation as a condition in which the etiological factor may be hypothyroidism. He describes a case showing a series of roentgenograms that he believes to be a hypothyroid heart. It was associated with a history most typically that of hypothyroidism plus physical findings, a low metabolic rate, and rapid response to thyroid medication with recurrence on controlled lapse of medication with prompt recovery on re-institution of treatment. Digitalis, rest, etc., had not brought about recovery in six weeks previous to the use of thyroid extract.

Backache in the lower lumbar region and right adnexal pains of a vague and disassociated type are frequently complained of, particularly by young females. Headache is of relatively frequent occurrence. Stevens reports a three-year observation in a special department for the study of headaches in the Cornell Clinic, New York City. He describes a group which he attributes to hypothyroid conditions, as follows: The sufferer is a woman past middle life; in the majority of cases is married and has borne children; is likely to be over-weight; the temperature is sub-normal, sometimes as low as 96.5; the pulse is slow, and blood pressure low; the skin is dry and coarse; the hands and feet are cold; tactile sensation is diminished. The most prominent subjective symptom is headache, which is usually frontal. The vertex is also a common site. The headache is dull in character and may occur every day; more, often two or three times per week. It may be constant day and night. The pain, unlike that of migraine, is rarely severe. It is aggravated by fatigue and nervous tension. Vertigo is common. The basal metabolic rate is found to be between minus two and minus twenty. This taken in conjunction with the rapid improvement following the administration of thyroid extract was considered suggestive of a relationship; he further remarked that in their experience this headache has no counterpart in the male; also that women who have been subject to migraine in earlier life are very likely to suffer from this headache at the menopause.

Another very important group of findings from the standpoint of frequency of occurrence is dryness of the skin and hair, necessitating the frequent application of lotions and other emollient substances to control chapping, roughness, and scaling of the skin. According to Engelbach, alopecia areata is frequently found. Loss of the outer one-third of the eye-brows is a frequent characteristic sign. Thinning and premature greyness is manifested occasionally. The skin and mucous membranes are pale, due to the secondary anemia which is usually present. Bridges reports the association of pigmented patches, but does not consider them pathognomonic of any given pathology.

Menstrual disturbances are frequently encountered. Menorrhagia is the most usual and is often very severe and resistant to ordinary therapy, responding only when thyroid medication is instituted. Amenorrhea is reported as being frequent occurrence in the experience of some authors.

Sterility is a frequent complaint which brings these cases to the physician. General examination may result negatively, or only some of the minor stigmata of hypothyroidism found. Fatigue and chilliness will usually be present. Sperm of the husband is found to be satisfactory. Huhner's test reveals active sperm in the cervical

canal, uterosalpingography reveals a patulous genital tract; uterus may be smaller than normal and antiverted. The metabolic rate will be found low. Thyroid medication persevered in will very frequently, in the writer's experience, be followed by fertilization of an ovum and pregnancy.

There is a lowered resistance to infection as manifested by the frequency of colds, coryza, rhinitis, and respiratory infections.

Hallucinations and illusions as pointed out by Beck of Baltimore may be present. These were first pointed out by Prof. Murray of Manchester in the chapter on thyroid diseases in the Twentieth Century Practice of Medicine published in 1901. Dr. Beck calls this the Murray Syndrome. He reviewed 194 consecutive cases of thyroid deficiency including mild and severe cases in which 51, or 26%, manifested some form of hallucination of sight, and a smaller group, hallucination of hearing. The most common form of hallucination is when small animals, such as mice, rats, cats, etc., are running around the floor. It is difficult to establish the occurrence of hallucinations because of a natural reluctance to acknowledge their occurrence. Hearing voices, wavelike motions of the pavement when walking, are other forms of hallucination. These are relieved entirely by the administration of thyroid extract.

The urological symptoms associated with thyroid deficiency are in a series of one hundred cases studied by Gregsky; nocturia, pyuria, dysuria, oliguria, and incontinence.

The objective symptoms of most importance are obesity, which has a fairly characteristic distribution, namely padding of the dorsum of the hands and feet, around the wrist and ankles, fingers and toes; in the supraclavicular space and the dorsal cervical area. In the more extreme cases there is generalized obesity. The pulse is slow; under excitement or in consequence of intercurrent infection the pulse may be rapid and weak. The blood pressure is low, usually below 110 in adults; the temperature is subnormal. Glucose tolerance is increased; the basal metabolic rate is lowered, minus ten to minus thirty being the ordinary range. Sloan emphasizes the fact that fever, digestion and exercise must be considered in determining the basal rate. Pregnancy is also an important factor. These points cannot be stressed too greatly. The patient's pessimistic, irritable, depressed state still further favors this condition, and as a result the reading is often not basal, and in the presence of a typical history and physical examination we get readings from zero to plus fifteen. A repeat examination at a later date will give a reading of minus ten to minus thirty in the same case. In my estimation one reading is not desirable or accurate, especially if higher than seems consistent with facts. It is trite to remark that the errors where the patient is to blame will always be toward the positive side.

The urine may contain a trace of albumin, and the nitrogen products in the blood be increased. These clear on treatment and these facts suggest the absence of organic disease of the kidneys. Secondary anemia with the relative lymphocytosis is frequently found.

DIAGNOSIS

Diagnosis is based on the lowered B. M. R.; the history of mental and physical fatigue; lassitude; cold extremities; dry skin and hair; obesity with a typical disposition plus the association of the many factors discussed above. Here a paragraph from Laurence seems appropriate: "Fatigability without organic disease, diminution of renal function without nephritis, slowness of the pulse without anemia but with lymphocytosis, and subnormal temperatures call for an investigation of the endocrine condition of that patient."

PITUITARY DISTURBANCES

In pituitary disturbances the obesity is of the girdle type with enlarged breasts, there being little increase otherwise; the skin is soft; hair is oily and bitemporal headaches are complained of. There is also an abnormal distribution of hair on the face, between the breasts, on the abdomen and arms. Sugar tolerance is increased; the blood pressure, pulse and temperature are normal, or only slightly sub-normal. Sexual frigidity of the acquired type and sterility are frequent.

It is an interesting observation of long standing that pituitary disturbances almost invariably follow prolonged hypothryroidism and vice versa, so that in late cases we often have to contend with thyro-pituitarism or pituitary thyroidism, so designated, depending on which preceded the other. Such diagnosis of a bi- or pluri-glandular disturbance is made by recognition of the distinct glandular involvement.

HYPO-ADRENALISM

Hypo-adrenalism is another disease entity which must be differentiated from hypothyroidism. The work of Koehler has done much to clarify this field. He makes the following points of differentiation. The onset in hypothyroidism occurs as a familial type, at the menopause, or following colloidal degeneration of the thyroid, or after thyroidectomy. It can, as previously mentioned, follow prolonged fatigue, acute illness, child bearing, etc. Hypo-adrenalism, on the other hand, usually has its onset in one of two ways, either concurrent with, or following infectious or toxic state, or due to exhaustion as the result of great stress or strain.

The character of hypothyroidism is usually gradual in onset, and continues with moderate constancy. In hypo-adrenalism the onset is usually sudden, with temporary periods of remission. Rest and vacation improve the condition, while over activity aggravates it. The physical aspects of hypothyroidism are usually over-weight, and present the picture delineated above. The adrenal case is usually under weight. There frequently is vaso-motor instability with flushing. The hands and feet perspire freely. Blood pressure is very low, by about ten points on the average than in hypothyroid cases. The temperature and pulse are low, but in hypo-adrenalism increasing the metabolic rate with thyroid extract does not alter the situation. Nervous stability in adrenal cases is more pronounced. They are often termed high strung, or hyper kinetic type of individuals. The metabolic rate is lowered in both, the average being distinctly lower, however, than in hypothyroid. In the graphic readings there is a greater tendency to erratic respiratory movements in hypo-adrenalism. Hypo-adrenal cases are also much more sensitive to anoxemia, which is perhaps responsible for the prominence of the symptoms of smothering in these cases.

Therapeutic tests are quite conclusive. The spectacular results of thyroid medication in hypothyroid is never achieved in hypo-adrenal cases.

Exogenous obesity, pernicious anemia, and tuberculosis etc., are ruled out by the history, physical examination, and laboratory findings.

PROPHYLACTIC

Iodine should be given to pregnant and nursing mothers; it should also be given to children in the pre-adolescent and adolescent periods of development. Metabolic studies and thyroid extract where indicated should be made on pregnant women who present the stigmata of hypothyroidism.

TREATMENT

Thyroid extract should be given by mouth in varying doses to bring about a restitution of the metabolic rate and relief of symptoms. The dose varies from one-half grain (½ gr.) to six (6) or eight grains (8 gr.) per day; the average being about one grain (1 gr.) three (3) times a day. An attempt to establish the dose just below that level produces tachycardia (pulse rate over 96) nervousnss, restlessness, tremor, insomnia and emotionalism. The basal metabolic rate is to be maintained between plus five and plus ten.

Since the pharmacological action of thyroid substance depends on its iodine content, it is well to remember that the products of different manufacturers vary. Burroughs Wellcome & Company product contains 0.08% of iodine; Armour & Company and The Lilly product, 0.2%; Parke Davis & Co., 0.3%.

Frequent observation until the optimum dose is established is very important, and thereafter sufficiently frequent observation to keep the patient well controlled.

The Surgical Treatment of Pulmonary Tuberculosis; Part II*

By J. W. GALE, M. D.
Madison

Phrenicotomy is rapidly becoming popular with continued usage. Great strides have been made since 1922 when Felix (9) cleared up the problem of accessory nerves to the phrenic which had previously defeated in many instances the real purpose for which the operation has been performed. The operation preferred at the present time is phrenic exairesis. The technique of the operation as described by Matson (16) is as follows: The approach is made through the subclavian triangle just below the omohyoid muscle because, if anomalies exist or accessory fibers are encountered, they may be best exposed in this area. The skin and subcutaneous tissues are infiltrated with .5% novocaine. The incision is made in a skin fold transversely between the posterior border of the sternocleidomastoid and the external jugular vein 2 to 3 cm. above the clavicle. Following the skin incision the superficial fascia, platysma, deep fascia and pyramidal fat body are carefully separated by blunt dissection. This exposes the phrenic nerve coursing downward and inward over the anterior scalenus muscle. The nerve is then separated from the muscle sheath. After freeing the nerve from the muscle, it is injected with .5% novocaine, clamped with a hemostat and divided. The nerve is then carefully evulsed by making gentle traction or by winding it on the hemostat which is rotated. Sometimes the nerve can be evulsed in its entirety. Some surgeons prefer going higher in the neck, thereby avoiding important structures, but in cases of abnormality the lower exposure is more adequate. Other surgeons do the operation described by Goetze (11).

The indications for phrenicotomy are numerous, and the effects of the operation are regarded by different surgeons from many view points. Davies (8) in listing the indications for phrenic evulsion lists them under eight general headings: "1. As a means of arresting disease in cases of basal tuberculosis. 2. In association with local thoracoplasty. 3. To assist in controlling the disease in more generally extensive or more advanced or more acute cases of pulmonary tuberculosis. 4. As an accessory to pneumothorax treatment. 5. In the treatment of symptoms. 6. As a preliminary to radical treatment of tuberculous empyema. 7. As a preliminary to thoracoplasty. 8. In order to free the heart from embarrassment." Under each heading he gives a more detailed description of the conditions considered. These indications seems to be a fair example of those generally accepted today. Alexander (2) and Matson (16) express similar ideas. Matson, however, regards the operation in certain cases as an independent procedure. This idea will doubtless become more popular in the future because of his results.

EFFECTS OF PHRENICOTOMY

A break in the continuity of the phrenic nerve with all of its accessory branches produces a complete permanent paralysis of the corresponding half of the diaphragm. This paralysis results in a rise of the paralyzed half to the expiratory position with subsequent degeneration, thinning and atrophy of the muscle fibers. The rise is most frequently greater on the right side. The maximum rise does not occur for several months following operation.

There is a decrease in the volume of the hemothorax and a diminution of the vital capacity, there being later partial compensation for the latter. The lung is relaxed and compressed, and existing cavities which had previously been held open by adhesions may now contract and finally disappear with healing. Apical, as well as basal, cavities are effected to a similar degree. There is a degree of lymph stasis.

Other effects noted are relief from a preexisting intractable cough due to the tug on adhesions between the base of the lung and

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the diaphragm. The sputum may become increased for a short period of time, but later it usually decreases. Then again it may be uninfluenced. The general condition as a result is greatly improved and signs of toxemia decrease. We cannot always expect the maximum beneficial effects. In certain instances the diaphragm does not rise and troublesome adhesions may prevent the desired effect.

RESULTS OF PHRENICOTOMY

A very excellent and complete report has recently been published by Matson (16) covering a group of 66 cases treated by phrenic exairesis. Sixty-three of these cases had positive sputum. In all cases the disease was of the productive type, exhibiting the characteristics of an upper lobe lesion. In 34 cases a thoracoplasty was contraindicated. Following exairesis 52% were so improved that a thoracoplasty became unnecessary.

In 32 cases where a thoracoplasty was indicated 28% were so improved that operation was not done. Forty-two per cent of the 66 cases developed a negative sputum. Only two cases in the two groups were worse following operation.

These figures are very encouraging and go to prove that phrenic exairesis may yet become an independent procedure. Certainly, if carried out as a test operation for the integrity of the other lung, the preliminary use as such becomes more indicated by the high percentage of improvements. If thoracoplasty is still indicated, the patient is much better able to resist the shock of the operation and the sudden additional strain mentioned previously in this article.

INTRAPLEURAL PNEUMOLYSIS

As previously mentioned, this operation was first conceived and practiced by Jacobeus (14). It has certain advantages over the more radical treatment. The operation is carried out under local anesthesia, and no marked reaction is experienced by the patient. Certain cases are suitable for artificial pneumothorax were it not for thin strands of fibrous tissue between the visceral and parietal pleura which prevent complete collapse of the lung. Not infrequently these adhesions occur at points where collapse is most desired. Attempts made to stretch them are not always successful; and, unless other methods are used, the pneumothorax must be abandoned. Its use is many times contraindicated. Adhesions may be so large that burning through them is impossible. They may be too numerous to make the operation practical. Other cases are unsuited because of cavities extending out into the adhesions holding them open. Division in this case would bring about contamination of the pleural cavity with a resultant pyogenic or tuberculous empyema. The operation is not simple, and only those skilled in the handling of Jacobeus' instrument should undertake the procedure.

The results even with division of the adhesions may be disappointing because of the complications arising after the operation. Attempts are sometimes made to divide adhesions that are too broad, and severe hemorrhage may result. Opening into a cavity accidentally may cause widespread pleural involvement. In the absence of infection, pleural exudates are not uncommon and may result in a complete obliteration of the pleural space and later thoracoplasty will have to be done or local collapsing of the cavities by the extrapleural route. The mortality rate following this operation combined with the complications resulting reaches close to 10%.

EXTRAPLEURAL PNEUMOLYSIS

This operation, like intrapleural pneumolysis, does not have a wide range of indications. In certain instances cavities appearing in the apex over which the two pleural layers are densely adherent and where, following artificial pneumothorax or paravertebral thoracoplasty, the cavities still persist, this operation may be tried. It consists of stripping the parietal pleura from the endothoracic fascia and overlying ribs over the area occupied by the cavity. The result is a retraction of the two pleural layers and the underlying lung inward from the thoracic cage, which, due to adhesions, had prevented collapse. Sometimes this space is filled with paraffin, muscle fat or gauze tampons which maintain the lung cavity in a collapsed state.

When gauze is used, it must be removed later and the cavity allowed to heal by granulation. Theoretically, the operation is excellent, but, since foreign bodies must be introduced for pressure, they are not infrequently expelled through the wound. They may erode the underlying pleura due to pressure and the paraffin fillings are sometimes coughed up. The result then is a bronchopleural fistula which is a very troublesome and distressing complication. Now and then large serous exudates collect around the fillings and have to be aspirated repeatedly, thereby increasing the chances of infection and expulsion of the tampon or filling. The fat fillings may absorb and prove entirely inadequate. The operation, however, is worthwhile in certain cases of intractable hemoptysis where thoracoplasty is contraindicated because of the condition of the patient, and artificial pneumothorax or phrenic exairesis has been unsuccessful.

MULTIPLE INTERCOSTAL NEURECTOMY

This operation was first brought to our attention by Alexander (3) about one year ago when he published his results on six cases. He tells us that it had previously been performed on animals as early as 1913. The earlier reports, however, were inadequate. The operation as described consists of a straight incision over the angles of the ribs from the second to the twelfth. The intercostal nerves are identified and sections of about 2 to 3 cm. removed from each rib, second to eleventh inclusive. Alexander states that the indications are similar to those for artificial pneumothorax, thoracoplasty and phrenicotomy. The disease should be predominately unilateral, and any lesion in the better lung should not be actively progressive. Productive lesions react better than exudative ones. It should be used only after the failure of more conservative methods.

The operation results in great immobilization of the diseased lung. Certain cases without large cavities or high grade contraction not infrequently need artificial aid other than the more conservative means. For this group this operation has been advised. The contraindications have also been listed; these deal with patients in very poor general condition, with weakened hearts, or in the terminal stages of tuberculosis. If the sputum is over 100 cc. per day or if dyspnoea is marked due to adhesions and traction, it is also inadvisable.

The six cases reported by Alexander point to definite clinical results warranting its use under the indications stated by the author.

SUMMARY

Surgical intervention is now offering heretofore unthought of chances to those cases of chronic tuberculosis which have always been considered hopeless. The percentage of cases in which surgery can be successfully carried out is small when compared to the number of cases suffering from the disease, but the good results so far obtained are more than sufficient to warrant its use.

Those cases of unilateral involvement with the chronic productive cavernous or noncavernous lesions which have had an adequate sanatorium regime and where artificial pneumothorax cannot be instituted react best to operation. The type of operation which succeeds in the most adequate immobilization of the lung and most rapid healing is the paravertebral extrapleural thoracoplasty. The patients with acute exudative lesions do not react well to collapse therapy.

Phrenic exairesis has proved its value as a test in cases where the contralateral lung is under suspicion, in conjunction with thoracoplasty, and as an independent procedure.

Other operations, as extra- and intrapleural pneumolysis and multiple intercostal neurectomy, are more limited in their application, but, where indicated, have produced very gratifying results.

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Balance in Therapeutics

By H. P. GREELEY, M. D.
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Medicine exhibits all varieties of practitioner. From the Quack, who practices "Salvation by Faith" aided by a useless armamentarium and without benefit even of a diagnosis, to the Nihilist who practices "Salvation by Works" without the aid of any armamentarium or with the aid of a few drugs, tried and true and a careful and particular diagnosis. These men who, in principle, are as far apart as the Poles, in practice are often equally successful; because we cannot deny that the Quack often gets results and that we often fail. Our batting average year after year would put us far in the lead, but the Quacks' occasional home run is what keeps them in the game and pleases the people on the bleachers.

In between these extremes of Quack and Nihilist are the average men of the profession—some of them faith healers too—some careful, well-balanced clinicians. The faith-healer is a sincere, but self-deluded man who listens to the enthusiastic detailman and grasps at one new preparation after another, a gullible convert to the velvet words and personal testimonial of that lowest form of animal life inside the profession,—the ex-doctor salesman, who has often personally experienced the remarkable benefits attributed to this new preparation. It may be something for the relief of asthma or high blood pressure, ulcer of the stomach, migraine, or cystitis. The detail man claims to have had them all, only stopping at epilepsy and gonorrhea.

The faith healing physician with his newest and best and ever enlarging and changing armamentarium is by no means a careless man or a poor practitioner, though at times he is a threat and a liability. His results are good. He may be a careful and painstaking man, but deluded. His results

compare favorably with those of the well-balanced clinician who clings to his meager equipment of drugs—a dozen or so—bromides, iodides, digitalis, mercury, arsenic, strychnine, salicylates, alkalies, and a few more. Both are careful clinicians. Both study their patients thoroughly. Both use all at their command which will benefit the whole patient. They do not fail to avail themselves of what is accomplished by a carefully outlined regimen; regularity and temperance in habits of living, careful diet, properly regulated exercise and rest, cleansing of the body inside and out; and a proper balance between sympathy and encouragement.

Now take the average physician as defined above and the average patient. How shall we define the latter? For some physicians he would have a minor industrial accident; for others something else. At any rate the average patient is not found in a hospital ward, so let us arbitrarily define the average patient as a medical out-patient. Then we should include an indefinite group of cases of indigestion, rheumatism (muscular, neuritic and articular pain), cardiovascular disease with high blood pressure, headaches, nervous debility, upper respiratory infections, malnutrition, and over weight. These and a few more probably make up three-quarters of those seeking the help of a physician. Most of them whom we see are still in a mild stage of pathological change, a few, more advanced.

Now what have we to offer such a group? Specifics, no; cures, by any method, no! What have we then? Relief through the care of the patient; sometimes complete and permament, sometimes partial and temporary. Take one as an example. High blood pressure, that fashionable and much abused and over-rated symptom. What does the average man do for the average patient? There are those who use the iodides, others the nitrites, still others the theobromine derivatives, and others sulphocyanate, liver preparations, bismuth nitrate, and a host of others. Being almost entirely ignorant of the cause, there are one-thousand and one remedies for lowering blood pressure. Aside from the factor of heredity and the fact that the life insurance tables show that seventy-five per cent of the people with high blood pressure are markedly over weight we have little to go on in etiology. The fact that there are so many remedies means there is none. Successful treatment depends upon striking a proper balance between energy intake and outgo, avoiding over alimentation, promoting efficient combustion and elimination, and regulating rest and exercise. This is the Alpha and Omega of the treatment of high blood pressure. The balance of power then lies with natural measures,—Diet, Rest, Exercise, Elimination, Cheer, and proper mental attitude toward this much feared and over worked symptom high blood pressure. Drugs are useful in maintaining cardiovascular efficiency at crises, but of little value over a period of years in the continued care of these patients.

Go to any medical convention and listen to a dissertation upon high blood pressure: Definitions, suggested etiology, proposed medical management, this drug and that drug in considerable detail, then almost as an afterthought and apologetically a concluding paragraph on general treatment,—short and without much emphasis. The truth and success of treatment lie in a balanced temperate life—a regulated regimen. The drugs are handles by which we keep our patients and talismans to which patients cling with a faith which is the legacy of medieval times.

How about the indefinite raff of conditions diagnosed as rheumatism, arthritis, myositis, neuritis, muscle strain, etc.? After searching for foci of infection and eliminating them, often though not always with considerable disappointment in results, we give the salicylates, cinchophen, and oxoate and colchicum and lithium salts and oxyliodide, etc., and use all kinds of electrical machines and lights. When all is said and done we rely mostly on the natural measures,—diet, elimination, rest, heat, massage and graduated exercise.

Headaches offer a similar problem and their name and variety are legion. After "eliminating" eyes, acute sinus infection and trifacial neuralgias we fall back upon

the commoner types "bilious" headache and "nervous" headache. Then we run the gamut of therapy; coal tar products, treatments of the nose and operations on the nose; we straighten out the mental life of the individual and attempt to help him, or more frequently *her*, to make a more satisfactory adjustment to job, ornery employer, sex difficulties, fear of pregnancy or cancer or a difficult mother-in-law. For the "bilious" headache we prescribe diet, exercise, recreation and elimination, knowing that generally that phrase biliousness means too much food and too little exercise—a lack of balance between energy intake and outgo. For the nervous type we rely upon psychotherapy, relaxation and recreation, work and interest of a character which will be absorbing and diverting, diet, exercise, cheer, elmination, friction baths, massage.

And so we may go through the list of functional disturbances of digestion, over weight and under weight. There are thousands of preparations for the treatment of these and many other conditions, each helpful but none indispensable, each a more or less important adjunct to the care of the patient, that care being primarily based on a study of the patient's habits and make-up and a correction of those habits where they work toward the patient's loss of efficiency.

Look over the figures of food consumption and reckon the cost of the annual medicine bill in the United States today compared to 25 or 50 years ago; the amount of sugar, coffee, coca cola, tobacco, meat, and candy consumed together with excesses of all kinds. Then consider the mortality tables—the so-called "prolongation of life." Statistics prove that the *average* length of life is 15 years longer than it was 50 years ago and by this every man on the street thinks that he has been granted 15 years more life in which to work and live. But the truth is that not one single year has been added to the life of the man on the street. The increase in life expectancy is all at the other end in the saving of infants and young adults. Actually more people are dying in the sixties now than formerly. In other words, after you arrive at the age of sixty you have less chance of reaching seventy than your father did or your grandfather when they became sixty (if they did) and at fifty years your chances of reaching sixty are no better.

And what has reduced the infant mortality? Clean food has been responsible for most of it, though diphtheria toxin-antitoxin and better control of the contagious diseases is a big factor. Infant hygiene is our mainstay in reducing infant mortality. Again it is the natural methods of care that are all important—cleanliness and nutrition and sunshine and fresh air.

How feebly and inadequately do patients in poor nutrition and with poor elimination respond to any kind of drug therapy? And how different is the story when they are built up. Does this mean that their bettered nutrition gives them more natural resistance or that the drug is better acting? How frequently have the older syphilologists remarked upon the failure of specific treatment in anemic, run down patients. Improve their nutrition and build up their blood and then their antiluetic treatment is successful. Does the patient make a recovery which is partly due to his own development of immunity toward the syphilitic virus independent of mercury and iodide? We know that there is recovery from syphilis without treatment. Are patients built up with drugs? They are only adjuncts, often unimportant.

One of the foremost public health officials has frequently said that a fortune could be made by the man who patented some innocuous, flavored water and sold it with full and careful directions as to its use. These directions would embody the best rules of personal hygiene, so much and such a selection of food, so much water, so much daily exercise and rest. It would not be necessary to use salicylates, iodides, nux vomica, or any of the rest of the list. People's health would improve. The bottle of water would satisfy their craving for a crutch and their improved hygiene would accomplish the work.

There are few specifics. Patients recover under our care and even when they are not under our care; they recover under anybody's care and under nobody's care.

Our drugs weigh heavily in the mental balance both with physicians and patients, but very lightly often in the scales of scientific medicine.

CONCLUSION

Let us not over-rate the drug, nor neglect the patient and his hygiene. There never was a time when there was a more wholesome need for a return to the natural aids in therapy, nor a time when the value of these measures should be more thoroughly recognized by the profession at large. I do not wish to belittle the great contributions which pharmacy has made in recent years to medicine. We all recognize the tremendous strides that have been made in modern pharmaceutical chemistry. But there is tremendous rivalry and competition and for every half dozen real advances in pharmacologic preparations there are hundreds of useless preparations, or old preparations with new names foisted on us by the high pressure salesmen. There is not nearly as much drugging as there used to be, but there is still far too great faith in the pink pill and the elixir, the capsule and the ampoule. Let the gullible beware. A few case reports do not make a great advance in therapy; nor does one swallow make a specific. Keep the drug trade out of your office and keep his periodicals in your waste basket. Study medicine in medical literature and clinic, not in the drug pamphlet, or at the hands of the detail man.

As Osler wrote, "As the public becomes more enlightened and as we get more sense, dosing will be recognized as a very minor function in the practice of medicine in comparison with the old measures of Asclepiades."

THE JOURNAL CLINIC

A Diagnostic Problem

By E. L. BOLTON, M. D., and R. J. WINKLER, M. D.
Appleton

Case No. 2859J, a young adult white male, age 20, was admitted to the hospital September 8th, 1930. Complaint was—pain in right upper quadrant of abdomen, slight productive cough, general feeling of malaise, rash (generalized) and yellowish discoloration of skin (without itching).

Patient had been an employee of the Plankington Packing Company of Milwaukee, working on the gut conveyor for the past two months.

Family history negative, all members alive and in good health.

Personal History: Has had the usual childhood diseases. No history of scarlatina, rheumatism, malaria nor typhoid. Always

Fig. I. Shows character of rash and peeling. Patient deeply jaundiced.

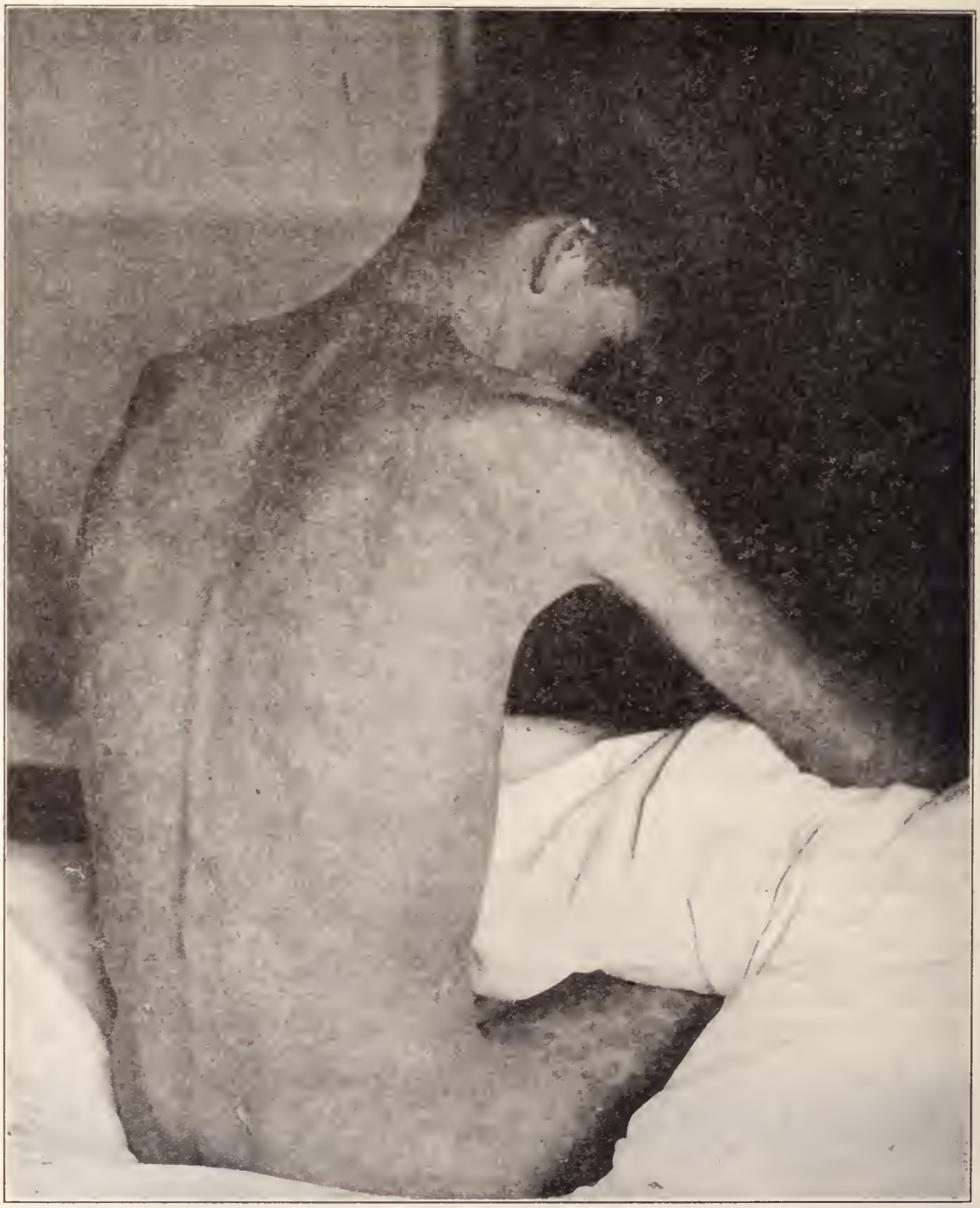

Fig. II. Another view. There are no blebs. Scales dry.

has enjoyed good health and has been using no drugs. Denies venereal infection. Smokes moderately and denies drinking.

Onset and Course: Present complaint started two weeks ago while working, with pain in the epigastrium, most marked on right which was not severe. On the fourth day he started to break out with small red spots below the eyes. At this time patient stopped working and came home. Rash gradually progressed downward until five days ago it covered the whole body. At this time he went to see a doctor who gave him medicine for his stomach and liver. About

Fig. III.

five days ago patient started to become yellow—first the eyes and then the whole body. Patient was constipated at this time. He had another attack of severe pain in the right upper quadrant of the abdomen. Nothing was done for it and it passed away during the night. During this attack of pain he vomited for the first time and continued to vomit once in the forenoon for the next four days—watery, bitter vomitus. Pain and tenderness, which are still present in upper abdomen, do not radiate to any particular part. Had his first chill yesterday, and does not know whether or not he had a temperature previously.

Patient has done considerable belching during illness and urine is becoming scant and highly colored.

About four days ago patient developed a cough with pain in both chests which is still present. Skin began to peel on face, scalp, hands and feet. Places where rash started first were the first to begin to peel.

No history of hemorrhages nor bloody stools. Is beginning to feel very drowsy and is losing weight.

Positive Physical Findings: Temperature 100.4, pulse 86, respiration 20. Blood pressure 120 systolic and 80 diastolic. Pulse rate and tension normal. Well developed and nourished male, apparently quite ill. Entire body covered with a rash that appears purpuric. The blotches are round in contour, not raised, and disappear on pressure. Between these blotches the skin is a deep yellow and apparently does not itch much. Peeling of skin of face, neck, hands and feet. Sclera is yellowish—no pupillary signs. Pharynx injected somewhat—tonsils small. Adenopathy nil. Heart—apex within the nipple line in fifth intercostal space. Rate and rhythm normal—no murmurs. Lungs grossly negative except for a slight impairment to percussion and weakness of breath sounds in right lower. Coarse rales scattered throughout both apices. Tenderness in right upper quadrant of abdomen. Abdomen slightly distended. No masses made out. Liver palpable two centimeters below costal margin. Spleen not made out. No abnormal reflexes found. No edema. There are two brownish spots on the glans penis which he says developed with rash. Rectal negative, prostate small and not tender.

Appearance of the patient was much the same as is seen in the accompanying photographs which were taken on the third day in the hospital.

During the eleven days stay in the hospital the temperature did not rise above 100.6 and after the fifth day dropped to normal. Nothing characteristic about the temperature. Pulse did not rise above 86 nor go below 76. Respiration ranged from 20 to 22. Scaling continued and each purpuric spot peeled. Jaundice gradually lessened and tenderness gradually left abdomen.

Laboratory: Urine negative except for a trace of albumin, leucocytes and heavy bile. Specific gravity 1.022.

Blood on entrance:
Hgb. 83%
Color Index 1 plus
Coagulation Time 4′
R.B.C. 4,060,000
W.B.C. 16,100
van den Bergh 9.4 mg.
Icterus Index 44.0 mg.
Blood Wassermann negative.
S.L. 12%
L.L. 2%
P.M.N. 86%

Blood culture at one time showed a gram negative bacilli and four days later showed a gram positive spore former.

Agglutination tests negative for typhoid, paratyphoid, B abortus and B. Tularense. Stools contained some occult blood and were negative for parasites.

Left hospital still somewhat jaundiced and peeling, but able to be up and about. The last we heard of him—two weeks after leaving the hospital, all signs and symptoms had cleared up and he was feeling fine.

This case has been of interest to us from a diagnostic standpoint. Patient was seen by practically all of the physicians on the Hospital Staff, but no positive diagnosis has been made. We would be pleased to have suggestions made as to a diagnosis of this case.

Acute Intestinal Obstruction Complicating Induced Abortion

By T. W. TORMEY, M. D., and
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Madison

Case No. 65104—A widow age 43 was admitted to the Madison General Hospital at 9:00 P. M. on July 6th, 1930, and gave the following history.

Menstruation had been normal until April, 1930, but had not appeared since then. There were no other signs or symptoms of pregnancy, but the patient, thinking she was pregnant, decided to abort herself. She secured a piece of heavy clothes line wire about two feet long and made a loop out of it (Fig. 1). After boiling the wire she inserted it into the uterus and stated that it slipped in very easily but caused a dull ache in the lower abdomen, almost immediately. The pain gradually increased in severity, and when she tried to remove the wire she could not get it out. The local doctor was then summoned, and when he could not remove the wire had her transferred to the hospital. In the meantime the pain became intermittent and cramp-like in character and very severe. The patient, who has four children living and well, stated that she had used this same procedure on three previous occasions without any disastrous consequences.

Examination was essentially negative except for the presence of the wire loop in the uterus whose loose ends protruded about three inches outside the vulva. Leucocyte count was 15,500. She was taken to the operating room where preparations had been made for both abdominal and vaginal surgery. Under spinal anesthesia—a vaginal examination was made which showed that the wire loop was firmly held in the uterus and probably in the peritoneal cavity and a laparotomy was performed.

The wire had been forced through the fundus and a segment of ileum had been caught in the loop of the wire. When the patient had tried to remove the wire, she pulled the ileum down to the fundus of the uterus, and thereby caused an acute intestinal obstruction. The bowel was discolored

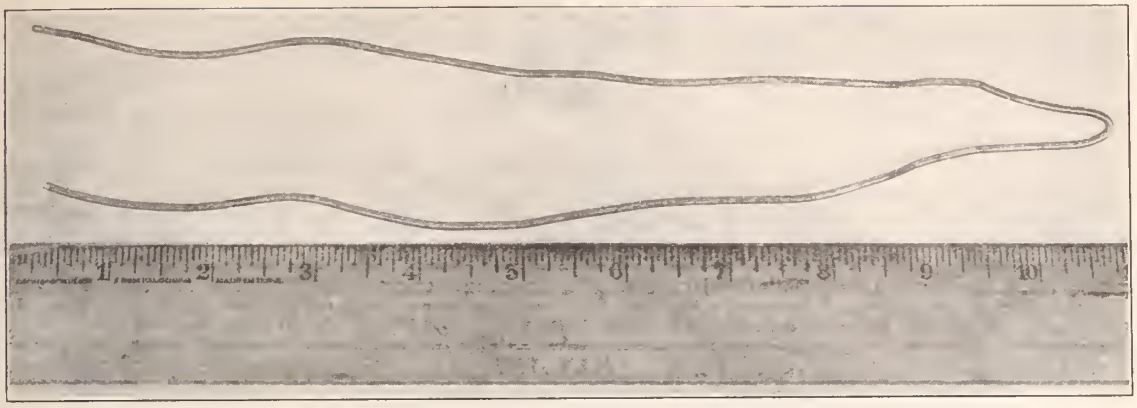

Fig. I. Wire loop used for abortion and forced through the fundus of the uterus.

and distended for several inches. It was a simple procedure to free the bowel from the wire loop, after which the wire was removed through the vagina. Two stitches of catgut closed the rupture in the uterine wall, and warm saline packs soon brought the discolored bowel back to normal. The abdomen was closed and the patient made an uneventful recovery, being discharged from the hospital on July 18th, or exactly twelve days after admittance.

Perhaps the most unusual phase of the entire case was that the poor widow was not pregnant.

An Unusual Pathological Result From a Fall

By C. F. N. SCHRAM, M. D.
Beloit

A man 25 years of age tripped in attempting to run and jump over a machine which was about 30 inches high. He fell forward with his arms, forearms and hands extended, landing on his hands (thenar and hypothenar eminences) and feet. He said his hands came in contact with the floor before his feet touched the floor.

He came to my office about an hour later complaining of pain in the upper third, muscles, of his forearms. There was some stiffness and a disinclination to pronate and supinate the hands, although it could be done both actively and passively. Elbow, wrist and hand movements were normal except for the uncomfortableness. There were no deformaties, crepitation, lacerations or abrasions.

Heat and rest were advised.

The following day, the patient returned with his elbows semi-flexed (135 degrees) and unable to flex the forearms on the arms. Hands were about two-thirds supinated and he could not pronate or further supinate them. Extension and flexion of the wrists were only slightly limited and the fingers and thumbs freely movable. Elbow joints were swollen and tender and the patient practically helpless as far as the use of his upper extremities were concerned. There was no pain except on motion.

X-rays were negative except for showing elbow joint surfaces farther apart than usual. My diagnosis at that time was that of a bilateral traumatic hydrops articulorum of the elbow joints.

The treatment of heat and rest was continued and he returned to work five days after the accident with a few of the limitations of motion remaining, but all markedly improved. There developed on the third day following the accident, an ecchymosis of the inner aspect of both elbows, extending half way in circumferences of the forearms and arms and covering the upper half of the forearms and the lower fourth of the arms. This was still present when the patient returned to work but was fading. There was also a slight amount of fluid in each joint.

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EDITORIALS

THE BEAUMONT MEMORIAL

AT THE meeting of the State Medical Society at Milwaukee last September there was distributed a leaflet which set forth the reason why the work of Dr. William Beaumont should receive some recognition at the hands of the medical profession in Wisconson.

This is further emphasized by the fact that one hundred years ago, last March, Dr. Beaumont completed at Old Fort Crawford, Prairie du Chien, a series of experiments on Alexis St. Martin, the man "with a lid on his stomach." Of these he published fifty-six, and they formed the foundation for his further experiments and our present-day knowledge of Digestion.

St. Martin received his wound in the trading post of the American Fur Company at Mackinac, and it was from this place that Beaumont published his account of the injury and a few of his preliminary experiments; but none of them are included in his *Experiments and Observations on the Gastric Juice, and the Physiology of Digestion*, Plattsburgh, 1833.

Recognizing the importance of Beaumont's work, the Upper Peninsular and Michigan State Medical Societies erected at Mackinac, in 1900, a memorial to Beaumont.

Other memorials have been erected at Lebanon, Connecticut, Beaumont's birth-place; St. Louis, Missouri, where Beaumont died; and at Plattsburgh, New York, where Beaumont published his book.

Wisconsin is to be congratulated that steps have been taken to erect a suitable memorial to Beaumont, at Prairie du Chien, during the present year. W. S. M.

RAISING THE ANTE

COLLEGE authorities hold out for the necessity of four years being devoted to acquiring a bachelor's degree. The public accepts that and the students and their parents make the sacrifice in time and thousands of dollars to secure the oftentimes doubtful advantage the degree is supposed to confer.

But let a youngster break down with tuberculosis at this age. Can we doctors get four years and the expenditure of several thousands of dollars with which to effect a cure? Very exceptionally, and then as a rule only after the patient has done badly instead of brilliantly in his learning how to live and restore his health.

We have compromised too readily in the past and it is now time to begin to establish our standards and demands after the manner in which educators have established theirs. The latter do not apologize for their inability to snatch a youth from the jaws of Ignorance in a grudgingly given three or six months. Why should we be asked to perform miracles against TUBERCULOSIS? H. E. D.

NOT SO BAD

ONE of the best things that can be said about the oncoming generation of young physicians, educated in the best of colleges, is that they are not being permitted to be narrow technicians. And this is very important in a profession which, from its nature, requires its practitioners to know such a vast number of technical facts and procedures.

A student brought into contact with, let us say, a thousand cases of silicosis at one time, even though it be only in a course in Sociology or Economics, will never again fail to see through and beyond the individual chest to the millions of other working men's chests. Seeing, he will be shocked into study of causes and to inventing or utilizing preventive measures to put a stop to the wholesale manufacture of silicosis in workmen's lungs.

No educated gentleman can see broad and think narrow! If, at times, we seem to have only a narrow vision, it is due, for the most part, to the fact that as yet we have not had the opportunity or the obligation to see whole. Certainly no profession or social class is better prepared than we to "see what we are looking at" in a large way, and when we physicians see well we act well. Medicine has always been, and will be to the end of time, a glorified service and ministry to all humanity,—not far below that of angels and saints idealized in the ancient religions. H. E. D.

APPRECIATION OF SERVICE

WE are pleased indeed to note that a component society has recently decided not to approve a concerted publicity program, having for its object the education of the public to a greater appreciation of the services of the medical profession.

If the medical profession feels that the public does not sufficiently appreciate its services, might it not be worthwhile to look into the cause of this lack of appreciation? Is it possible that the fault may lie at our own door?

Are we giving every patient that comes to us for medical advice a square deal? Do we go into the history of complaints as conscientiously as we should; do we give our patient a careful physical examination to discover a possible hidden cause for his complaints; are we prepared to give him the best treatment that is at the command of modern medicine?

The practice of the average physician in Wisconsin is still today more or less a personal one. He deals with the individual as a rule, and not with the public at large. Give the individual patient the services that he has a right to expect, and appreciation will not be lacking.

But to be deserving of their confidence we must be in a position to earn it. Interest in the patient, thoroughness in the examination, and rational scientific therapeusis will do more to gain the respect, confidence and appreciation of the public than any amount of printer's ink. O. L.

MEDICAL JOURNALISM

AFTER an avocational experience of about thirty years in medical journalism, I have very strong reactions from time to time on the question of what it is all about. Sometimes getting out a medical journal seems very well worth while; at others, not worth cutting down beautiful trees out of which to make paper on which to spread half-baked ideas in ill chosen words.

And occasionally, after being bored to tears by the ponderosity of an inspired but uninspiring medical essayist, I turn with relief to some of the better edited house organs of commercial drug manufacturers. That makes me, for one, wish that we could get a larger number of equally well prepared, terse medical articles and comments in this JOURNAL. Articles, of course, not inspired by commercialism but solely by the desire to give as much instruction and information as possible in the fewest words. H. E. D.

Here's hoping we beat "Tonics and Sedatives" to it. Last month, in our editorial columns, we referred to *Tombs* of medical writings instead of *Tomes*. Not so sure, however, that the meaning is so very different in the long run.—H. E. D.

THE PRESIDENT'S PAGE

C. A. Harper

VACCINATION

TO WRITE of vaccination against smallpox is to revive a time-worn subject with a voluminous literature covering more than a century. Yet certain foreign countries are giving more concern today to the results of vaccination and the method of procedure than they have in the last quarter of a century. The physician of 1831 probably received advice upon the prevailing method of procedure as much as the physician of today.

A layman might wonder why, after the experience of all these years, a standard method of vaccination had not been evolved long ago. The answer is that the refinements in the production and marketing of vaccine have permitted changing methods. The old methods of scarification of a large area, cross hatching, and the use of shields resorted to a generation ago are now bad practice and should never be used.

Physicians connected with the United States Public Health Service have in recent years studied vaccination from its various angles and have finally done much to point to its proper performance. Under the date of 1927, that service reported results of tests with tetanus inoculated vaccine upon animals. A considerable number of monkeys and rabbits received liberal doses of this tetanized vaccine. In some of these animals the vaccination wound was covered with a shield or dressing and in a greater number of them tetanus developed in due time. Those animals in which the dressing was removed in eighteen hours had much less tendency toward tetanus. In the animals in which the vaccination wound was allowed to go entirely uncovered, tetanus did not develop. The lesions covered with a shield or dressing remained moist and necrotic and offered fertile ground for the proliferation of the tetanus bacilli, while those having no shields or dressing were moist for a few days only and tended to become covered with a dry and firm protective crust.

Since the results of the experiments were made known, many physicians are now advocating a dropping of dressings altogether. It can at least be said that it is the best practice to dispense with dressings altogether or if they are used they should be extremely light in character and discontinued in a short period of time. In the case of unclean underclothing, it is always possible to fasten gauze to the inner part of the sleeve.

In making this an arbitrary rule, one wonders if there may not sometimes be a risk of sepsis in some individuals and perhaps the physician could be guided in such cases in his judgment upon the necessity of a dressing. Vaccination shields should under no consideration be used and the application of bunion pads is highly dangerous as they have been found to harbor tetanus bacilli.

The modern method of vaccination provides for the entry of the vaccine into as small an area of broken skin as possible. A short line drawn through a drop of vaccine, the abrasion of the skin in match-head sized area by means of a needle, and the use of a vaccine drill made for the purpose are all correctly used methods. The multiple puncture method with a blunt needle through a drop of vaccine, however, offers new opportunities of avoiding septic difficulties and is now being widely advocated. The adoption of the latter method appears to be a real advance of a scientific nature in the field of vaccination.

Vaccination is generally regarded as a trivial surgical performance, yet its application requires careful technique, a certain degree of skill, and upon the universality with which it is correctly applied depends much of the success of the public response to the measure.

Smallpox in its various types is widely prevalent in the human family, notwithstanding the century of attempts to overcome it. While usually the mild type prevails in Wisconsin there are outbreaks of serious nature occasionally occurring. The milder types have done much to mitigate the popular fear of the disease and vaccination, except where urged or forced in local campaigns, is commonly neglected. In proportion as it is neglected, the way is opened for serious small pox outbreaks.

It is the universal history of smallpox that the ailment occurs most frequently in those not vaccinated. Among the 530 cases of malignant type existing in Wisconsin in 1925, 427 had never been vaccinated and the majority of the remainder had been vaccinated many, many years before. The physician is usually a modest man and adverse to the advocacy of measures that may have the aspect of favoring his pocketbook. Nevertheless, in the interest of a well ordered society, he should benefit his patients and his community by the advocacy of this particular measure. Do not the ethics affirm such procedure?

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SOCIETY PROCEEDINGS

BROWN-KEWAUNEE

The March meeting of the Brown-Kewaunee County Medical Society was held at the Beaumont Hotel on March 19th. Dinner was served at six o'clock.

Dr. C. J. Chloupek of Green Bay gave a very interesting talk on his recent trip to Europe. He visited clinics in England, Germany and Austria, and in his talk he described some of the recent advances in the treatment of various forms of arthritis and other diseases. His talk was enjoyed very much.

The business meeting was taken up in the discussion of the economic phase of medicine. Several plans for dealing with the indigent poor were proposed and discussed. A motion was made by Dr. E. S. Schmidt to appoint a grievance committee, the object of which would be to refer all matters of a controversial nature to such committee for investigation and disposal. This motion was carried. There being no other business the meeting was adjourned. E. S. K.

CALUMET

The regular monthly meeting of the Calumet County Medical Society was held at New Holstein on March 10th. The meeting was called to order by Dr. A. C. Engel, and the secretary presented the minutes of the last meeting which were approved.

Following this, matters concerning business were presented. A committee composed of Dr. N. J. Knauf and Dr. J. J. Minahan was appointed to confer with the county nurse on matters pertaining to the Society. Also a discussion was had in regard to news items. The topic concerned was that names of physicians who are taking care of the infirm are not to appear in any of the news items in local papers. The meeting was closed with a moving picture on "Traumatic Surgery." A. F. S.

CHIPPEWA

A meeting of the Chippewa County Medical Society was held at the Hotel Northern, Chippewa Falls, on Tuesday evening, April 7th, with a dinner at seven o'clock.

Dr. John W. Harris, professor of obstetrics and gynecology, University of Wisconsin, spoke on "Recent Advances in Clinical Obstetrics and Gynecology." It was a very interesting and instructive meeting. Twenty-three were present. J. A. K.

DANE

The Dane County Medical Society met on Tuesday evening, April 14th, at the Wisconsin General Hospital, Madison, at eight o'clock.

Dr. W. D. Stovall of the State Laboratory of Hygiene, gave an address on "Cancer: A Public Health Problem."

"The Early Recognition and Treatment of Pre-Cancerous Lesions" was the subject of a talk by Dr. E. F. Schneiders, Madison.

DOUGLAS

Members of the Douglas County Medical Society met on April first at the Androy Hotel, Superior. Dinner was served at six thirty o'clock. This was followed by an address by Dr. Eben J. Carey, Milwaukee, who spoke on "Pathology and Physiology of the Healing of Bone."

FOND DU LAC

Dr. E. R. Schmidt, professor of surgery, University of Wisconsin, addressed the members of the Fond du Lac County Medical Society on "The Surgery of Perforating Ulcers" at a dinner meeting at the Hotel Retlaw, Fond du Lac, on April 1st.

MARINETTE–FLORENCE

The Marinette–Florence County Medical Society held its monthly meeting, Thursday evening, April 23rd.

Dr. John W. Towey of Powers, Mich., and Dr. W. A. Alexander of Iron Mountain, Mich., presented a symposium on "The Collapse Therapy in Tuberculosis." This was illustrated with slides and x-ray films taking up in detail the injection of the nitrogen gas and filtered air in the pleural cavity; the severing of the phrenic nerve, and the resection of the ribs.

Dr. A. T. Nadeau, Marinette, presented a specimen with slides of a primary, carcinoid tumor, removed with an inflamed appendix in a woman thirty-three years old.

There were twenty-one members present and all enjoyed the turkey dinner. M. D. B.

OUTAGAMIE

Dr. John F. Schneider of Oshkosh addressed the Outagamie County Medical Society at its April meeting at the Hotel Northern on April 23rd. Dr. Schneider talked on "Obstruction of the Urinary Tract" and was illustrated with motion pictures and lantern slides. A dinner preceded the address.

POLK

The Polk County Medical Society met on Thursday, April 17th, in the Osceola Hotel at Milltown and had as their guests the editors of Polk county. Dr. L. O. Simenstad of Osceola entertained the group at a seven o'clock dinner at the hotel.

Dr. E. A. Meyerding, secretary of the Minnesota State Medical Association, and Dr. W. A. O'Brien, pathologist at the University of Minnesota, were the principal speakers at the meeting. Dr. O'Brien

spoke on the public health in the average communities while Dr. Meyerding discussed the health of the child in the home.

A discussion followed which involved advertising to a certain extent and publishing of health talks in the newspapers by local physicians.

RACINE

The regular meeting of the Racine County Medical Society was held at the Racine Elks Club on Thursday evening, April 23rd, at eight o'clock.

Mr. H. L. Fogelman, educational director of Standard American Corporation of Chicago, gave a talk on "Success Through Profitable Investment."

Dr. F. D. Murphy of the department of internal medicine at Marquette University, spoke on "The Diagnosis and Treatment of Heart Failure."

WINNEBAGO

Dr. Phillips F. Greene, associate professor of surgery, University of Wisconsin, addressed the members of the Winnebago County Medical Society on the subject of "Chinese Medicine" at a meeting on March 20th held at the Woman's Exchange Grill, Oshkosh.

MILWAUKEE ACADEMY OF MEDICINE

The Milwaukee Academy of Medicine held a meeting on Tuesday, March 24th, the following program being presented:

1. Some Interesting Cases of Bundle Branch Block by Dr. John Huston, Milwaukee.
2. Diseases of the Kidney by Dr. Francis Murphy, Milwaukee.

The members met again on Tuesday, April 14th. Speakers at this meeting were: Dr. M. Q. Howard, Wauwatosa, who spoke on "Treatment of Drug Addiction with Sodium Amytal" and Dr. E. W. Miller, Milwaukee, whose subject was "Electric Burns."

MILWAUKEE HOSPITAL INTERNE'S ASSOCIATION

The members of the Milwaukee Hospital Interne's Association will be the guests of Dr. E. A. Fletcher at a dinner given at the Milwaukee Club, 402 Jefferson Street, on Wednesday, May 13th, at 6:30 P. M.

Dr. Fletcher will speak on Some Urological Conditions, and Mr. Theodore Wiprud, Secretary of the Milwaukee County Medical Society, will discuss some of the problems of the Society.

WISCONSIN UROLOGICAL

The spring meeting of the Wisconsin Urological Society was held on April 11th at the Wisconsin General Hospital, Madison, at ten A. M. The program given in the morning follows:

1. "Vesico-Ureteral Reflux" by Dr. James Christiansen, Waukesha.
2. "Ureteral Catheter Drainage in Ureterotomy" by Dr. S. M. Turkeltaub, Milwaukee.
3. Case Reports by Dr. H. M. Stang, Eau Claire.
4. Case Reports by Dr. F. E. B. Foley, St. Paul, Minn.

Following luncheon served at the Hospital, the afternoon program was presented. Speakers and their subjects were:

1. "Bilateral Congenital Hydronephrosis and Hydro-Ureteral Angularity" by Dr. E. W. Exley, Minneapolis.
2. "One Interesting Case of Carcinoma of the Bladder" by Dr. George Ewell, Madison.
3. "Innervation of the Bladder" by Dr. D. K. Rose, St. Louis.
4. "Surgery of the Nerves to the Bladder" by Dr. J. R. Learmonth, Rochester, Minn.
5. "Encrusted Cystitis" by Dr. W. M. Kearns, Milwaukee.
6. "Unusual Renal Anomalies" by Dr. N. G. Alcock, Iowa City.

Dinner was served at six o'clock at the Madison Club.

UNIVERSITY OF WISCONSIN

Dr. Irving S. Cutter, dean of the Medical School, Northwestern University, delivered the William Snow Miller lecture on "The History of Puerperal Fever" before a meeting of the University of Wisconsin Medical Society held on March 30th at the Service Memorial Institute Building.

NEWS ITEMS AND PERSONALS

Twenty-two members of Mercy Hospital staff, Janesville, met in monthly business session on April 2. Following a six-thirty o'clock dinner, Dr. George W. Bartels presented a paper on "Hematuria." Drs. Fred B. Welch and Frank W. Van Kirk were named to draw up resolutions on the death of Dr. G. K. Wooll.

—△—

Dr. Burton Clark, Jr., of Oshkosh is taking postgraduate work in surgery at Lakeside Hospital, Cleveland.

Dr. W. P. Tippet, Green Bay, a sergeant in the medical corps during the World War, received a croix de guerre and a citation from the French government in March. Dr. Tippet was credited with crawling out to a shell hole during the height of a battle near Soissons to rescue a medical corps major. Recommendation for the medal was made many years ago.

—△—

A permit has been issued to Dr. F. C. Christensen, Racine, for the construction of a new clinic building at 209-211 Eighth Street. The cost will be $20,000.

Dr. William F. Lorenz, Madison, gave a lecture on "The Effect of Sickness on Personality" under the auspices of the social service department of the Milwaukee Episcopal diocese, at St. James' Episcopal church, Milwaukee.

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Dr. and Mrs. Wilbur N. Linn, Oshkosh, returned from a three weeks' trip to Pacific and southwestern states, traveling by train. Most of the time was spent in California, Oregon and Washington. They also visited in Mexico. At Pasadena, they attended the annual Wisconsin picnic held on February 14th.

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A two-story building and adjoining lot at 1228 N. Eighth Street, Sheboygan, has been purchased by Dr. Conrad Tasche for the purpose of establishing new office headquarters for himself and his son, Dr. Leslie Tasche. Work has been started remodeling the entire second floor to provide for offices, a surgical room for minor operations, and x-ray room. The lot will be used for a driveway and parking space.

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Dr. R. C. Buerki, Madison, gave an address on "The Relation of the Hospital to the State" before a meeting of the Steuben Society on March 30th at the Park Hotel, Madison.

—△—

Dr. C. F. Myre, Chippewa Falls, has been appointed assistant physician at the Northern Wisconsin Colony and Training School at Chippewa Falls. He succeeds Dr. Weaver, who resigned recently on account of ill health.

—△—

Dr. William Snow Miller, emeritus professor of anatomy, University of Wisconsin, quietly observed his 73rd birthday on March 29th at his home in Madison. Members of Phi Beta Pi, medical fraternity, entertained at dinner on March 30th in his honor.

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Dr. R. J. Winkler, formerly associated with the Bolton-Mielke Clinic at Appleton, has purchased the residence and office of the late Dr. Fred Dehne of Hilbert.

—△—

Dr. A. S. Jackson and Dr. Harold Marsh, both of the Jackson Clinic, Madison, spoke before the annual meeting of the American Association for the Study of Goitre, which met in Kansas City, Mo., from April 7th to 9th. Dr. Jackson is one of the executive councilors of the group and was chairman of the program committee.

—△—

Dr. C. A. Harper, president of the State Society, addressed the joint annual meeting of the Wisconsin Association of School Boards and members of the City Superintendents Association of Wisconsin held at Madison. His subject was "The Teacher's Health."

Dr. W. C. Stewart of Kenosha spoke on "Tuberculosis" before a meeting of the Round Table Club at the Hotel Dayton, Kenosha.

—△—

Racine's city health activities have won first place in its class in the 1931 inter-chamber health conservation contests, according to a telegram received from the secretary of the United States Chamber of Commerce.

—△—

Dr. H. W. Howe, formerly of Sheboygan, has opened offices in the Commercial National Bank building, Fond du Lac. For the last three years Dr. Howe has been in Europe where he took postgraduate work.

—△—

Dr. C. H. Barnstein of Newton, secretary of Manitowoc County Medical Society, visited the offices of the State Medical Society at Madison on April 18th.

—△—

Dr. R. C. Buerki, superintendent of Wisconsin General Hospital, Madison, has been named superintendent of the new State Orthopedic Hospital at Madison by the University Board of Regents.

—△—

Dr. O. M. Layton of Fond du Lac, gave an address on the history and development of medicine before a meeting of the Robert Blow Men's Club of Grace Episcopal Church of Sheboygan.

—△—

A two-story clinic building is being erected at 815 St. Clair Avenue, Sheboygan, for Dr. William Van Zanten and his son, Dr. Wesley Van Zanten, and associate specialists, and it is to be ready for occupancy July first.

The main floor of the building will have eight office rooms and a reception room. In the basement will be the x-ray equipment and other laboratories. The second floor will be made into seven apartments.

In addition to Drs. Van Zanten, a dentist, eye, ear, nose, and throat specialists and other physicians and surgeons are to be associated in the new clinic.

—△—

Dr. and Mrs. W. M. Trowbridge, Viroqua, returned on May 1st from a vacation spent in St. Petersburg, Florida.

—△—

The State Historical Museum, Madison, has been presented with a French clock from the Prairie du Chien home of Dr. William Beaumont by Ida M. Street, whose father purchased the clock from Dr. Beaumont.

—△—

Dr. A. J. Hockett, a former interne at Wisconsin General Hospital, who is now practicing medicine in the state of Oregon, will return to Madison this summer to take over the position held by Dr. J. T. Morrison as chief resident physician in the State Hospital.

Dr. and Mrs. W. M. Nesbit of Madison visited at Miami Beach, Florida in April.

—△—

Dr. Jerome R. Head, son of Dr. Louis R. Head, Madison, has been appointed chief of the chest department of the government diagnostic clinic at Maywood, Illinois, a veterans' medical unit serving 22 states.

—△—

Dr. J. B. MacLaren of Appleton spoke before a meeting of the Rotary Club of Green Bay on April 16th.

—△—

Dr. Phillips F. Greene, associate professor of surgery, University of Wisconsin, will return the middle of August to China, after having spent nearly four years in Madison. Dr. Greene will be under the Yale University unit at Changsha, Hunan, where he was previously located, and will head the surgery unit in that hospital.

—△—

Dr. G. H. Stannard, Sheboygan, has donated a tract of land on his farm between Greenbush and Glenbeulah for a baseball diamond for the Greenbush players. The Greenbush team is in the Kettle Morraine league. He will also erect a grandstand and furnish necessary equipment.

—△—

The 32nd annual meeting of the American Proctologic Society will be held at Philadelphia on June 7, 8, and 9, 1931. All regular practitioners are invited to attend the scientific sessions on the 8th and 9th.

—△—

At the Marinette annual council meeting Mayor Murray re-appointed Dr. T. A. Lid, city physician. Dr. J. W. Boren was held over for another year as health officer.

—△—

Dr. and Mrs. T. J. Redelings, Dr. and Mrs. Edward Sawbridge and Dr. Luella E. Axtell, all of Marinette, have returned from their trip through the Panama Canal and the Pacific coast. Dr. and Mrs. G. R. Duer also of Marinette, are home from a visit to Havana.

MILWAUKEE

Dr. A. L. Banyai presented a paper on Diabetes and Pulmonary Tuberculosis at the staff meeting of the Muirdale Sanatorium on April 7.

—△—

Dr. and Mrs. A. J. Patek left on April 11th for a visit in Charleston, S. C. They expect to return by way of Washington where they will attend the Elizabeth Sprague Coolidge Chamber music festival.

—△—

Dr. J. F. Zivnuska returned the first of April from a visit to Miami, Florida.

—△—

Dr. M. Fernan Nunez, Professor of Pathology at Marquette University appeared before the Knights of Columbus April 7th. His subject was Spain Yesterday, Today, and Tomorrow.

—△—

Dr. John J. Pink, Jr., was appointed Captain in the Medical Reserve Corps, according to an announcement released by the War Department on April 4.

—△—

Dr. Charles Frank, of Chicago, has been appointed to the medical staff of the National Soldiers' Home, it was announced on April 3, by Col. Charles N. Pearsall. Dr. Frank already has resumed his duties at the Home. He was formerly a physician and surgeon in Chicago, and this is his first position in the service of the National Home.

—△—

Dr. Charles E. Ide on April 2nd announced the removal of his office to the Bankers Building, 208 E. Wisconsin Avenue, Milwaukee.

—△—

Dr. Eben J. Carey, professor and director of the department of anatomy at the Marquette University School of Medicine, presented a paper and scientific exhibit, on the factors controlling the healing of fractures and curvatures of the spine, before the annual meeting of the American Association of Anatomists at Northwestern University in Chicago, on April 2.

—△—

Dr. E. L. Tharinger, president of the Medical Society of Milwaukee County, and Mr. Theodore Wiprud, executive secretary, are to give a series of talks to the seniors of Marquette University Medical School on Medical Organization and Medical Economics. The first talk was given on April 13.

—△—

Dr. David H. Mehigan spoke at the third of four bi-weekly meetings of the 1931 School of First Aid and Health, sponsored by the Association of Commerce, on the subject of First Aid in Fracture Cases. His talk was given in the Public Museum on March 31.

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Dr. and Mrs. William Thorndike left on March 31 for Summerville, S. C.

—△—

Dr. and Mrs. A. W. Gray returned from Baltimore, Md., on March 30. Dr. Gray attended the meeting of the American College of Physicians.

—△—

Dr. Oscar Lotz attended the annual meeting of the American College of Physicians which began on March 23, in Baltimore, Md.

—△—

Dr. George E. Whalen returned from St. Petersburg, Florida, on March 28.

—△—

Dr. George K. Pratt, assistant medical director of the National Mental Hygiene Committee, addressed a luncheon meeting of the Milwaukee branch of the American Association of University

Women on March 28. His subject was Safeguarding Mental Health—A Community Problem.

—△—

Dr. and Mrs. Stanley J. Seeger returned on April 10 from a visit to San Antonio, Texas.

—△—

Mrs. Anna Frances Mollinger, wife of Dr. S. M. Mollinger, died on March 26. Mrs. Mollinger was 49 years of age.

—△—

Mr. George Schweitzer, father of Dr. George J. Schweitzer, died on March 23.

—△—

Dr. and Mrs. A. E. Mieding returned March 21 from a six weeks' motor trip in Florida.

—△—

Dr. and Mrs. George A. Carhart returned from a cruise of the West Indies on April 3.

—△—

The last general session of the Practical Postgraduate Course in Chest Diagnosis, sponsored by the Medical Society of Milwaukee County, was held on April 6. Dr. W. S. Middleton of Madison was the speaker. All those enrolled agreed that the course had been a splendid one, and very profitable. It is planned to sponsor similar courses in the coming year.

—△—

The following health talks sponsored by the Wisconsin State Board of Health were broadcast over the Milwaukee Journal Station WTMJ during April:

April 14—"Indigestion."
April 28—"Mental Hygiene: An Important Public Health Problem."

These talks were delivered by Mr. Theodore Wiprud, executive secretary of the Medical Society of Milwaukee County.

Time was relinquished by the Wisconsin State Board of Health on the following dates: April 7 and 21, for radio talks given by Mr. H. H. Jacobs, Educational Director of the Wisconsin Anti-Tuberculosis Association, in the interest of the Early Diagnosis Campaign.

April 7—"The National Campaign for the Early Diagnosis of Tuberculosis."
April 21—"How Our Knowledge Can Fight Tuberculosis."

These talks are given each Tuesday at 5:45 P. M.

—△—

A definite announcement concerning the Medical Arts Building to be erected in Milwaukee by Mr. William Gettleman was released to the press on April 1. The building is to be 22 stories in height and of the very latest construction. Executive offices for the Medical Society of Milwaukee County are to be provided. The library of the Academy of Medicine will be moved to this building. Lounge, committee rooms, auditorium, and other facilities such as check room, kitchenette, etc., are to be provided for use by both the Society and the Academy.

Speakers who appeared for the Speakers' Bureau of the Medical Society of Milwaukee County during March were:

Dr. H. W. Powers, who gave a talk on Character Formation in the Child at a meeting of the Parent-Teacher Association of the Lee Street School on March 18;

Dr. L. M. Warfield, who spoke before the Twentieth Century and the Civitan Clubs. His subject was What You Should Know About Your Heart;

Dr. A. A. Pleyte, who discussed The Prevention of Common Diseases in Adolescence at the Wauwatosa Congregational Church on Sunday, March 22.

—△—

The medical service, sponsored by the Society, carried on at the Goodfellow House, continued during the month of March. Those who served during that month are: Drs. Wm. J. Voellings, W. P. O'Malley, Edward Jackson, Emmet Cook, John Freedman, Edward Gertenbach, M. B. Byrnes, C. V. Lynch, P. Perlson, Weber Hermann, Howard Hansen, F. J. Stirn, J. A. Jenner, Fred Selle, P. J. Niland, John McCabe, R. E. Olson, A. J. Ruppenthal, R. A. Teschan, W. P. Miller, Alfred Suhr.

—△—

The following committee of the Medical Society of Milwaukee County was appointed to co-operate with the Wisconsin Anti-Tuberculosis Association in their Early Diagnosis Campaign: Dr. R. W. Blumenthal, Chairman; Dr. R. J. M. Russell, Dr. R. M. Greenthal, Dr. John McCabe, Dr. Bruno Warshauer.

—△—

Dr. E. L. Tharinger, president of the Medical Society of Milwaukee County, appointed the following committee to plan for the quarters of the Society in the new Medical Arts Building: Dr. P. M. Currer, Chairman, Dr. R. P. Sproule, Dr. Edward Jackson, Dr. Charles Fidler.

—△—

A communication from Dr. Morris Fishbein, who recently conducted a course in medical writing in Milwaukee, advised that the prize-winning essays were submitted by the following members of the class: 1st prize—Dr. W. M. Kearns; 2nd prize—Dr. N. E. McBeath; 3rd prize—Dr. John W. Powers.

Dr. Fishbein sent each one of the prize winners a copy of his latest book, "Doctors and Specialists." These essays will be printed in early issues of "The Milwaukee Medical Times."

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A meeting of the Physicians' Service Bureau membership committee of the Society was held on March 25. The purpose of the meeting was to plan for the expansion of the Bureau service.

—△—

A meeting of the scientific exhibit committee of the Interstate Postgraduate Medical Association was held at the Hotel Schroeder on March 31. Dr. Eben J. Carey, chairman, called the meeting to order. Present were Drs. T. L. Squier, F. D. Murphy, H. B. Podlasky, E. J. Oesterlin, M. Fernan Nunez, John Grill, W. J. McKillip, F. W. Mackoy, W. J.

Carson, J. J. Gramling, J. E. Habbe, C. C. Schneider, Karl Schlaepfer, D. E. W. Wenstrand, E. W. Miller.

Plans were discussed in regard to scientific exhibits. A number of acceptances were read, and invitations to other groups suggested.

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The membership committee of the Medical Society of Milwaukee County held a meeting in the executive offices on April 1. Dr. R. P. Schowalter is chairman of this committee. Other members are: Drs. W. J. Carson, John Garvey, J. E. Habbe, and Stephen Cahana.

This committee has been very successful in obtaining a large number of interne members. They will continue their efforts to increase this class of membership.

—△—

A meeting of the child welfare and public nursing committee was held in the executive offices on April 2. Present were Drs. Millard Tufts, Chairman; H. B. Miner, and J. P. Koehler, of the City Health Department.

The purpose of this meeting was to discuss another joint campaign of the Society and the Health Department to eradicate diphtheria. It was suggested that the campaign should again be put on in August.

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Dr. and Mrs. R. J. M. Russell and Carol Russell were recent visitors at St. Petersburg, Florida.

—△—

Dr. and Mrs. Edward Quick have just returned from a few weeks' sojourn in California.

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At a style review presented for members of the Marquette University faculty wives and their guests, Dr. A. J. Caffrey talked on "Facts and Foibles of the Day." Mrs. J. R. Dundon is chairman of the entertainment committee.

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Dr. Morris Fishbein, editor of the Journal of the American Medical Association, Chicago, spoke before a meeting of the Rotary Club in Milwaukee on April 14th.

—△—

The first of a series of talks on Medical Organization and Medical Economics, to be given before the seniors of the Marquette University School of Medicine, by Dr. E. L. Tharinger, president of the Medical Society of Milwaukee County, and Mr. Theodore Wiprud, executive secretary, was given by Mr. Wiprud on April 13th. His subject was "Medical Practice in a Changing World."

The second talk in the series was given by Dr. Tharinger on April 20, when he addressed the seniors on "Industrial Medicine," and the third in the series was given by Mr. Wiprud on April 27, on "Organized Medicine Meets Current Problems."

—△—

Dr. and Mrs. F. J. Gaenslen returned about the middle of April from a cruise to Havana and Nassau.

Dr. and Mrs. R. W. Blumenthal recently returned from a motor trip through the south and west.

—△—

Dr. and Mrs. J. C. Bloodgood were honor guests at the April meeting of the business and professional women's section of the Women's Club.

—△—

Dr. C. A. Harper of the State Board of Health and Dr. John P. Koehler, Milwaukee Health Commissioner, were among the speakers chosen for the annual national child health day observance of the Mothercraft Training Society of the Maternity Hospital and Dispensary Association, held May 1, at the Pfister Hotel. The principal speaker was Dr. W. F. Draper, assistant surgeon general of the United States Public Health Service, Washington, D. C.

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Milwaukee hospitals will observe Hospital Day on May 12, by opening their doors for public inspection. There will be guides at every hospital to show visitors through the buildings.

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The following radio talks, sponsored by the Wisconsin State Board of Health will be broadcast over the Milwaukee Journal Station, WTMJ, during May:

May 5—"Psittacosis, or Parrot Fever"
May 12—"Care of the Hair and Scalp"
May 19—"Preventing Diseases of the Teeth and Gums"
May 26—"Cancer Control as a Public Health Problem"

These talks will be delivered by Mr. Theodore Wiprud, executive secretary of the Medical Society of Milwaukee County, at 5:45 each Tuesday.

—△—

The following members of the Medical Society of Milwaukee County rendered medical service at the Goodfellow House in April:

Dr. H. E. Webb, Dr. C. W. Long, Dr. J. W. Smith, Dr. J. G. Slaney, Dr. Jos. Russell, Dr. W. A. Brussock.

This service has been given to Goodfellow House since the middle of last December. It is expected that Goodfellow House will close May 1st. Officers of the medical unit of the National Guard have been making the sanitary inspections.

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Statistical records of Mr. Walter A. Drews, investigator for the State Board of Medical Examiners, show that in the last 18 months 97 persons caught practicing medicine without a license have been fined.

—△—

A staff meeting of Muirdale Sanatorium was held on April 21st. Dr. G. H. Jurgens presented a paper on "Pulmonary Tuberculosis in Adolescents."

—△—

The following speakers appeared for the Speakers' Bureau of the Medical Society of Milwaukee County:

Dr. John L. Garvey gave a talk on "Insomnia" at a luncheon meeting of the Exchange Club on April 16th.

Dr. H. W. Powers addressed two groups on April 17th. In the afternoon he talked to the boys of the Kilbourn Pre-vocational School on "Character Formation," and in the evening he spoke before the Center Street Pre-school Association on "Character Formation in the Child."

—△—

The chairmen of the committees of the Inter-State Postgraduate Medical Association of North America held a meeting at the Hotel Pfister on April 14. Dr. R. P. Sproule, general chairman, called the meeting to order. Present were Drs. R. P. Sproule, A. T. Holbrook, F. A. Stratton, J. M. King, C. H. Davis, H. J. Gramling, Edw. Henes, Jr., and Mr. Theodore Wiprud.

Dr. Henes explained that the purpose of the meeting was to point out the inter-locking activities of the various committees.

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Dr. Francis D. Murphy, appeared before the Racine County Medical Society on April 23. His subject was Diseases of the Heart. On May 27th he will appear before the County Medical Society of Beloit his topic for this occasion being Bright's Disease.

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Mrs. John Petrie, mother of Dr. Charles J. Crottier, passed away on April 12th at her home in Eveleth, Minnesota. Mrs. Petrie was 58 years of age.

—△—

Dr. Erwin von Graf, professor of obstetrics and gynecology, University of Vienna, gave a series of twelve lectures at the Marshfield Clinic during the week of March thirtieth. The lectures were attended by physicians from the surrounding communities and were very well received. In the afternoons he also gave demonstrations on the manikin on use of Kielland forceps.

—△—

Dr. Rock Sleyster, Wauwatosa, was honored late in March at Baltimore by election to the board of governors of the American College of Physicians and Surgeons. Two fellowships in the college were awarded to Wisconsin physicians. The recipients are Dr. Karl H. Doege, Marshfield, and Dr. Frederick Eigenberger, Sheboygan.

—△—

"The High Cost of Medical Care" was the subject of an address by Dr. V. F. Marshall of Appleton before a weekly meeting of the Menasha Rotary Club.

—△—

Dr. J. T. Morrison, for the past two years chief resident physician at Wisconsin General Hospital, Madison, left for New York to accept a position as associate director in the rural hospital division of the Commonwealth Fund. He will assume his new duties early in May.

Dr. I. G. Ellis, Chicago, has been named director of the x-ray department at St. Mary's Hospital, Madison, to succeed Dr. F. J. Hodges, who resigned recently to accept an appointment as professor of roentgenology at the University of Michigan.

—△—

Dr. Francis P. Daly, Reedsburg, has been appointed as deputy health officer for the fourth district to succeed the late Dr. I. D. Wiltrout, Chippewa Falls. Dr. Daly's district comprises fifteen counties, extending as far north as Superior. He plans to make his home in Eau Claire.

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Dr. J. M. O'Brien of Oregon, who was injured in an automobile accident, is recovering at St. Mary's Hospital, Stoughton.

—△—

Dr. and Mrs. E. V. Smith of Fond du Lac returned the first of April from their European trip. Clinics were visited at London, Berlin, Prague, Vienna, Berne and Paris. They were gone five weeks.

BIRTHS

A son to Dr. and Mrs. Isadore B. Reifenrath, Milwaukee, on March 23rd.

MARRIAGES

Dr. Mark Nesbit, Madison, to Miss Blanche Peterson of Minneapolis on March 28th at Minneapolis.

Dr. F. X. McCormick, Milwaukee to Miss Alice F. Reynold, on April 16th.

DEATHS

Dr. J. A. L. Bradfield, La Crosse, died suddenly on March 27th at Punta Gorda, Florida, where he was spending the winter.

Dr. Bradfield was born in East Fairfield, Ohio, on February 3, 1861. After attending college for two years, he was a teacher in the public schools of Woodford county, Illinois. His vacations were devoted to the study of medicine. In the spring of 1884 he began his study under Dr. L. A. Ferry of Eureka, Illinois, remaining with him two years. He then entered the College of Physicians and Surgeons, Chicago, from which he graduated in 1888. Immediately thereafter he went to Loyal, Wisconsin, where he opened an office remaining there two and a half years. He returned again to Chicago to take a special course in eye, ear, nose, and throat diseases. Completing this course, he moved to La Crosse.

Dr. Bradfield was a member of the La Crosse County Medical Society, the State Medical Society and the American Medical Association. He was also a member of the American Academy of Ophthalmol-

ogy and Oto-Laryngology and the American College of Surgeons.

He is survived by his widow and two daughters.

Dr. G. F. Andrew, De Soto, died from pneumonia on April 10th at a La Crosse hospital.

Dr. Andrew was born in Dubuque, Iowa, November 12, 1868. Upon graduation from Dubuque schools he studied medicine at Louisville Medical College, Louisville, Ky., completing his course in 1894. He immediately moved to De Soto to practice. During the World War, Dr. Andrew served in the hospital corps of the A. E. F. He had been elected mayor of De Soto in the recent spring election.

Dr. Andrew was a member of Vernon County Medical Society, the State Medical Society and the American Medical Association.

He is survived by his widow and two children.

Dr. Marshall T. Martin, Madison, died at his home on March 28th. He had been in ill health several years.

Dr. Martin was born in 1850. He had practiced for many years at Merrimac, Wisconsin. Since he came to Madison eleven years ago, he had retired from active practice. He was a graduate of Rush Medical College in 1880, and of Bellevue Hospital Medical College in 1881.

He is survived by his widow and one son.

Dr. John M. Sattler, Milwaukee, died at Deaconess Hospital on April 2nd.

He was born on June 11, 1870, in Germany, and when he was 15 came to the United States with his parents. He was a graduate of Keokuk Medical College in 1901. Before coming to Milwaukee six years ago, he had practiced medicine in Marion, Antigo, and Bear Creek, Wisconsin.

He is survived by his widow, one son and two daughters.

Dr. L. B. Hill, Baraboo, died on April 11th at the home of his son in Baraboo.

Dr. Hill was born in 1852 and was a graduate of Medical College of Ohio, Cincinnati, in 1879. On account of illness since 1926, Dr. Hill had retired from active practice.

He is survived by his widow and one son.

Dr. J. P. Thorne, Janesville, died on April 11th at his home in Janesville following several months' illness.

Dr. Thorne was born in Amboy, Ill., in 1868 and was a graduate of Northwestern University School of Medicine in 1890. Following graduation, he began his practice in Amboy, specializing in eye, ear, nose and throat diseases. Several years later he moved to Janesville where he had since remained.

Dr. Thorne was a member of Rock County Medical Society, the State Medical Society and the American Medical Association.

He is survived by his widow and two daughters.

Dr. Thomas Lucast, Birnamwood, died on April 15th after an illness of several months.

Dr. Lucast was born in the year 1870 and was a graduate of the College of Physicians and Surgeons, Milwaukee, in 1898. He came to Birnamwood a little over three years ago from Belle Plaine, Iowa.

He was a member of the Shawano County Medical Society, the State Medical Society and the American Medical Association.

He is survived by his widow and two sons.

SOCIETY RECORDS

New Members

Geo. D. Reay, Linker Bldg., La Crosse.
G. G. Mueller, Princeton.
H. V. Bancroft, Blue Mounds.
George Klinger, 118 W. Wisconsin Ave., Neenah.
A. F. Snyder, Baraboo.
Leo Hudson, Sauk City.
Francis N. Nimz, Iron Ridge.
George M. Hoffman, Manitowoc.
Denis Guzzetta, 138 North Avenue, Milwaukee.
Grant R. Curless, Public Service Bldg., Beloit.
F. B. Western, 1900 Washington Ave., Racine.
Raymond Mundt, Oconomowoc.
R. S. Hirsch, Lake Geneva.
Joseph V. Herzog, Elkhorn.
V. S. Downs, Lake Geneva.
D. F. Gosin, Green Bay.
M. C. Borman, 1545 So. Layton Blvd., Milwaukee.
S. H. Wolter, 213 W. Wis. Ave., Milwaukee.

Resignations

LeRoy Abbott, Wilton, Wis.
Homer Sylvester, Madison, Wis.
O. A. Christensen, Hawkins, Wis.

COOK COUNTY CLINICS

The annual post-graduate summer clinics conducted by Cook County Hospital, Chicago, under the auspices of the Chicago Medical Society will be held June 22 to July 3. Doctor N. S. Davis III, Secretary of the Society, reports that the clinics will be organized to give the practicing physicians in attendance practical instruction in the line of medicine and surgery. In fact, the two weeks will cover an intensive post-graduate study of the latest modern medical developments.

Medical men from all sections of the United States and Canada are expected to attend these clinics which will be held from eight A. M. to five P. M. each day and the lectures that will be given three nights each week at eight o'clock. Physicians desiring further information about this post-graduate course should write the Secretary of the Chicago Medical Society, 185 North Wabash Avenue, Chicago.

» » » CORRESPONDENCE « « «

BASIC SCIENCE BOARD

STATE BOARD OF EXAMINERS IN THE BASIC SCIENCES
(Anatomy, Physiology, Pathology and Diagnosis)

Madison, Wisconsin, March 31, 1931.

Mr. George Crownhart,
% Wisconsin Medical Journal,
Madison, Wis.

Dear Mr. Crownhart:

At the meeting of the Wisconsin State Board of Examiners in the Basic Sciences on March 21st I was instructed, as secretary of the Board, to furnish the Wisconsin Medical Journal with copies of the examinations submitted to applicants after each of the meetings.

I am herewith forwarding copies of the questions submitted at our last examination.* These are for publication in the Journal.

Sincerely,
ROBERT N. BAUER,
Secretary, Basic Science Board,
3414 W. Wisconsin Ave.,
Milwaukee, Wis.

* *Editor's Note.* The questions will be found in the last section of this issue.

BASIC SCIENCE BOARD MEETS

STATE BOARD OF EXAMINERS IN THE BASIC SCIENCES

Madison, Wisconsin, March 31, 1931.

Wisconsin Medical Journal,
Madison, Wisconsin.

Gentlemen:

The next examination by the Wisconsin State Board of Examiners in the Basic Sciences will be held on June 6, 1931, at the Hotel Pfister, Milwaukee, Wis.

Application for examination should be made to Robert N. Bauer, secretary, 3414 W. Wisconsin Ave., Milwaukee, Wis.

Very truly yours,
ROBERT N. BAUER,
Secretary, Basic Science Board,
3414 W. Wisconsin Ave.
Milwaukee, Wis.

"THE OFFICE NURSE"

Brandon, Wisconsin, April 7, 1931.

Mr. J. G. Crownhart,
Secretary and Managing Editor,
Madison, Wisconsin.

Dear Mr. Crownhart:

I am sending to you a piece of poetry written to me, by one of our patients.

Beatrice Comstock, seventeen years old, the above patient, has been coming to our office for ultraviolet ray treatments for nearly a year.

It would be greatly appreciated if you could use this poem in the Wisconsin Medical Journal.

Very truly yours,
HELMA LOOMANS,
An Office Nurse.

THE DOCTOR'S NURSE

A winning smile for everyone,
A bit of kindness, too;
In her way, she'll bring each day—
Some sunbeams, bright, to you.
No doubt you know to whom it is
I dedicate this verse—
It is, and could be, no one else
But the doctor's nurse.

Her patience is unfailing,
Her courage, too is strong;
And as she does her work each day,
Her heart is filled with song.
Go see the doctor when you're ill,
Before you can get worse—
But when you're blue—I say to you
"Go see the doctor's nurse."

—BEATRICE COMSTOCK.

POOR RELIEF RULING

THE STATE OF WISCONSIN
Office of Attorney General

Madison, April 8, 1931.

Dr. C. A. Harper,
State Health Officer,
Capitol.

Dear Sir:

You request an opinion on the following state of facts:

"A resident of the town of Buffalo, Marquette County, is afflicted with pernicious anemia. The patient in question is in extremis and the indicated medical care is the administration of liver extract in considerable quantity, daily, over a probable long period of time. Liver extract for the case of pernicious anemia is like unto the action of insulin for the diabetic.

"The patient and his family are so poor that they are unable to purchase this essential drug that is so necessary if life is to be sustained. The situation has been explained to the Town Chairman, Mr. Richard Proud, R. F. D., Montello, but we are advised that Mr. Proud refuses to authorize the purchase of liver extract as a form of poor relief," except upon opinion of the Attorney General.

I assume that Marquette County has not adopted the county system of poor relief. Therefore, under sec. 49.01, the town board not only has the authority, but the duty to relieve poor persons, and this

relief includes not only food, shelter, and clothing, but also proper medical attention. And it is not essential that the poor person be entirely destitute, but merely that he have not sufficient means to furnish all of these needs. Coffen v. Town of Preble, 142 Wis. 183.

The Attorney General rendered an opinion on January 25, 1929, XVIII O.A.G. 8, that insulin should be furnished under conditions similar to those you describe in the above statement of facts and in an opinion of March 18, 1931, this opinion was confirmed in another opinion of the Attorney General.

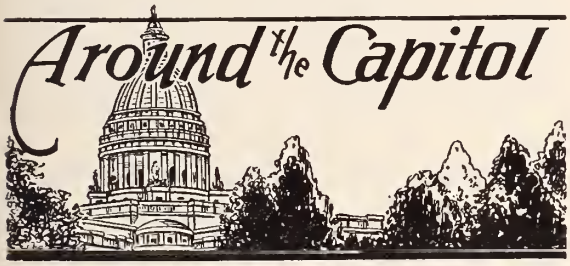
Attention is called to the requirement of the law that all poor relief, including medical aid, must be authorized by the town board prior to its furnishing, except temporary medical relief under sec. 49.18, which may be authorized by the town chairman.

Yours truly,

F. M. Wylie,

FMW:L *Deputy Attorney General.*

Caption: It is the duty of the town under the town system of poor relief to provide all medical relief for which the person has not the means to provide himself, although he may be able to provide all other means of existence, and this includes the furnishing of liver extract over a long period of time in a case of pernicious anemia.



The deadliness of the one-hoss shay is greater than that of Darius Green's flying-machine in Wisconsin, according to the bureau of vital statistics, state board of health.

Horse vehicles and horses, the bureau cites, caused 50 deaths in 1930, while aeroplane fatalities for the period reached a state total of 18.

Deaths from both these causes showed marked increase over the 1929 toll, the provisional report for 1930 indicates. Horse vehicles and horses caused but 29 Wisconsin deaths in 1929, while only eight aeroplane fatalities were recorded during the year.

Wisconsin's 815 auto accident deaths of 1930 will pale beside the 1,312 that will be chalked up this year if the January and February rate of increase in deaths from this cause prevails through the remaining months, it was announced by L. W. Hutchcroft, chief statistician of the State Bureau of Vital Statistics.

* * *

Rural home plumbing can be installed at approximately the cost of a low-priced car and maintained at less than $25 a year, yet less than ten per cent of Wisconsin's rural homes are so equipped, while some 80 per cent are provided with automobiles, according to Frank R. King, director of the bureau of plumbing and domestic sanitary engineering, state board of health.

* * *

In an opinion to F. W. Horn, district attorney of Forest county, the attorney general holds that services of a physician ordered by the county poor commissioner must be paid for even if the medical aid is extended to a family being given the support of a mother's pension. In this particular instance the mother was ill with typhoid fever and the doctor presenting the bill to the county was obliged to care for the woman's children.

* * *

After deliberation, the state board of health decided that persons who are "cousins and a half" to each other may not marry under Wisconsin laws.

Under the existing laws, persons who are nearer of kin than second cousins are not permitted to marry. For the first time, however, the legality of marriage between "cousins and a half" has been questioned.

* * *

Monroe county, as a result of the spring election, will retain its humane officer, but will dispense with its county nurse.

The humane officer referendum passed 4,162 to 2,976, while the nurse, Rosella Herman, was ousted, 4,299 to 3.842. The county agricultural agent office which advised farmers and stockmen was abolished in a third referendum, 4,289 to 3,749.

* * *

The supreme court has expressed surprise over an apparent sanction of "back seat driving" in a decision by Judge A. G. Zimmerman of Dane county circuit court and reversed his ruling in an automobile accident case.

Otto Goehmann and others brought a damage action against the National Biscuit company as a result of a collision. The Goehmann automobile emerged from a point near the "stop" sign on county trunk K in Dane county and was hit by the truck as it entered state trunk 51.

The jury found that the guests were negligent in not warning the driver of the auto of the approach of the truck.

The supreme court holds that under the circumstances there was no such duty on the guests.

"It is a general rule that passengers in an automobile must exercise due care for their own safety," the court says. "This requires them to exercise due care to keep a lookout, to warn the driver of approaching danger, to protest against excessive speed, reckless driving, and dangerous practices indulged in by the driver. The duty of 'driving from the back seat', however, has not been imposed upon passengers in an automobile, and we are a little surprised to find an apparent sanction of this abominable practice in this verdict."

Insulin Course Offers Help in Problems of Diabetes, May 18-23

To members of the Wisconsin medical profession the opportunity comes this month to take advantage of the Society's postgraduate course in the control of diabetes. Full details of the lecture course in the use of insulin were given in The Journal last month; the salient features will bear repeating in the interest of a large professional participation.

The purpose of the lectures and demonstrations at these one-day sessions is to assist physicians to master the technique of the use of insulin and to provide a preparation for the competent handling of diabetic patients in various stages of the disease. The course is so planned as to contribute definitely to the education of the lay public in the care of such patients.

The medical staff will comprise Dr. Leland S. McKittrick, Boston, Mass.; Dr. Russell M. Wilder, University of Chicago; and Dr. E. L. Sevringhaus, University of Wisconsin, assisted by Miss Lenore L. Healey, dietitian of the University of Wisconsin Medical School. At each clinic, also, local dietitians will assist the staff in demonstrating the approved procedures.

THE WEEK'S SCHEDULE

The schedule follows:

May 18, Madison, Wisconsin General Hospital.
May 19, Milwaukee, University Extension Center, 623 West State Street.
May 20, Oshkosh, Mercy Hospital.
May 21, Wausau, Hotel Wausau.
May 22, Eau Claire, Sacred Heart Hospital.
May 23, La Crosse, Stoddard Hotel.

Each class will start at 1 P. M. and continue until 6 o'clock. The discussions will bear on the following problems in diabetes:

Does the patient need insulin?
When is surgery safe?
Diabetic children.
Which diet?
Questions and informal discussion.
Blood and urine tests and demonstrations.
Management of coma.
Gangrene, osteomyelitis, and amputations.
How much can patients be taught?
Prepared foods and special recipes.
Liquid diets for emergencies.
Care of the feet.
Insulin injection.
Planning and serving meals. Demonstrations.

Dr. McKittrick's lecture on diabetic surgery will be illustrated with slides.

Every physician attending will receive a book of instructions on the dietary and other care of diabetics and the use of insulin.

INSTRUCTION OF LAY PUBLIC

The medical profession has constant evidence of the eagerness of diabetic patients and members of their families to know more about diabetes and its control. Diabetes must often be handled by the general practitioner in the home, relying on the patient and others in the home to carry out strictly the instructions of the physician. Continuous and meticulous care in diet regulation and the regular use of insulin is all-important.

The program will include a popular lecture for the general public each evening at 7:30 o'clock. Physicians are urged to have their patients attend and to bring the meeting to public attention. The lecture will be on "Diets, Diabetics, and Fat-Reducing Fads," by Dr. Sevringhaus.

The schedule of public lectures follows:

May 18, Madison, Room 230, Memorial Institute Building, North Charter Street.

May 19, Milwaukee, lecture hall, Public Museum, entrance on North Eighth Street.

May 20, Oshkosh, Vocational School.

May 21, Wausau, Central High School.

May 22, Eau Claire, High School.

May 23, La Crosse, Washburn School.

TRENDS IN DIABETES CONTROL

In the judgment of medical statisticians, the increasing use of insulin has avoided what would certainly mean a much higher diabetic death rate. Insulin has contributed to a definite prolongation of life for young diabetics; while older patients, once kept on a greatly restricted diet, may now, with the help of insulin, resume their former activities.

Although the idea that insulin *cures* diabetes is erroneous, it is a certainty that,

by the use of this agency, coma in diabetes is both preventable and curable. The patient is best safeguarded against coma if he is properly educated regarding his condition and adheres to diet and other prescribed precautions if he becomes ill. Hence there is a double responsibility upon physicians: To educate thoroughly their diabetic patients in regard to the dangers of coma, how it may be prevented and what to do if it does occur; and, if the emergency of coma appears, to insure that the patient receives careful and continuous attention for its treatment.

The present incidence of diabetes may be said to reflect the prosperity of the last few years. The consumption of sugar and the richness of the diet have a definite relation to the increase of diabetes in the population. During the World War, when diets were rigidly restricted, the diabetic death rate turned downwards. With better times returning, the disease again mounted. Women, whose economic status has greatly improved, began to show a much higher diabetic rate. Dr. E. P. Joslin of Boston, one of the outstanding specialists, reported that among his own patients the female list increased from one-quarter to more than half his total, the number having practically doubled in recent years.

Louis I. Dublin, Ph.D., the Metropolitan Life's statistician, writes:

"While the rise in the diabetes death rate is real and serious, it is not at all inconsistent with an increasing and more effective use of insulin. Were it not for insulin, the death rate from diabetes would have been much higher than it is, in view of the clear fact that more and more cases of the disease are being produced. Prosperity carries with it the penalty of a high diabetic death rate. It is in this way that our paradox is solved."

The insulin course is sponsored by the State Medical Society, the School of Medicine of the University of Wisconsin, and the University Extension Division. The fee, including book on the care of diabetic cases for physicians and patients, is $5.00. Application may be made to the University Extension Division, 314 Extension Building, Madison, or to the nearest field representative. The representatives are:

Appleton, 300 E. College Ave., M. C. Graff, Tel. 338; E. M. Gorrow, Tel. 338.

Eau Claire, 1316 Woodland Ave., O. L. Krasselt, Tel. 2476W.

La Crosse, 215 So. 19th St., B. W. Meyer, Tel. 1888M.

Madison, 314 Extension Bldg., Geo. A. Tyler, Univ. 30W.

Milwaukee, 623 West State St., N. D. Conners, Marq. 7051.

Oshkosh, 128 Central Ave., W. H. H. Liesch, Tel. 2900.

Radiological Section to Meet at Milwaukee May 27-29th; All Members of State Society Invited; Bloodgood to Give Clinics

The Wisconsin Radiological Section of the Wisconsin State Medical Society invites every physician to attend the spring meeting which will be held in the Schroeder Hotel from May 27 to May 29 inclusive. The feature of this meeting will be the Cancer Clinic by Doctor Joseph C. Bloodgood, of Johns Hopkins University. Doctor Bloodgood will discuss all phases of the cancer question.

There will be a meeting in conjunction with the Dental Societies on May 27, Wednesday evening, at which time tumors of the jaw will be discussed. All physicians are invited to include this meeting in their program. We urge all members of the dental and medical professions to bring material to this clinic.

Doctor Bloodgood asks that for all his work during these three days, individual members bring a short case history, pathological specimen, if possible, roentgenograms and any other material that may prove of interest in their cases, to the meeting. The scope and value of the clinics will depend on the amount and character of the material provided.

The rest of the program will consist of formal papers, round-table discussions, clinical—radiographic—pathologic conferences, technical demonstrations, banquet and business meeting. The Milwaukee Radiologists

hope to make this annual gathering of more than usual interest and value to you.

If you are going to present a case for diagnosis, please communicate at once with any of the following members:

Doctor Frank Mackoy, Sacred Heart Sanitarium.
Doctor N. Enzer, Mount Sinai Hospital.
Doctor H. B. Podlasky, Mount Sinai Hospital.

Be sure to send your material in as early as possible in order that Doctor Bloodgood may be informed as to how many cases will be presented. If you will send us your pathological specimens and roentgenograms at once we will have lantern slides made of microphotographs and roentgenograms.

Sample of type of case history which is to be short, stating all important features only:

Age
Race
X-rays
Bloodcount
Results
Sex
Trauma
Wassermann
Biopsy
Urine examination (if significant)
Treatment

Please remember that you must not state your diagnosis before Doctor Bloodgood asks for it at the meeting.

PROGRAM

WEDNESDAY, MAY 27th, 2 P. M.

1. Clinical—Radiological—Pathological Conferences.
   (a) "Metastatic Carcinoma of the Spine".
   Dr. F. J. Gaenslen, Milwaukee.
   Dr. F. C. Christensen, Racine.
   Dr. E. L. Tharinger, Milwaukee.
   (b)
   Dr. H. B. Podlasky, Milwaukee.
   Dr. N. Enzer, Milwaukee.
   (c) "Pulmonary and Cardiac Cases".
   Dr. T. L. Squier, Milwaukee.
   Dr. J. E. Habbe, Milwaukee.
2. Clinic—Bone Tumors.
   Prof. Joseph Colt Bloodgood, Johns Hopkins University, Baltimore.
3. "Spinal Curvatures".
   Prof. Eben J. Carey, Milwaukee, Marquette Univ. Medical School, Milwaukee.

WEDNESDAY, MAY 27th, 6:30 P. M.

Joint Meeting with the Milwaukee County Dental Society.

A. C. Rhode, D. D. S., President.

1. Dinner, Ball Room, Schroeder Hotel.
2. Clinic—Oral Tumors.
   Prof. Joseph Colt Bloodgood, Johns Hopkins University, Baltimore.

The Dental Society invites the members of the State Medical Society and visiting physicians to attend the dinner and clinic.

THURSDAY, MAY 28th, 9 A. M.

1. Radiation Therapy Symposium.
   Dr. Harry R. Foerster, Chairman.
   (a) "Common Skin Tumors of Interest to Radiologists".
   Dr. Norbert Enzer, Pathologist, Mount Sinai Hospital, Milwaukee
   (b) "Radiation of Spleen—Especially in Splenomegaly".
   Dr. T. Sokow, Roentgenologist, Kenosha Clinic, Kenosha.
   (c) "Radiation Therapy in Toxic Goiter".
   Dr. E. L. Jenkinson, Roentgenologist, St. Luke's Hospital, Chicago.
   Discussion opened by Dr. C. W. Eberbach, Milwaukee.
2. Clinic—Bone Tumors.
   Prof. Joseph Colt Bloodgood, Johns Hopkins University, Baltimore.

THURSDAY, MAY 28th, 2 P. M.

1. "Comparative Values of Intravenous and Retrograde Methods of Urography".
   Dr. Bernard Nichols, Roentgenologist, Cleveland Clinic, Cleveland.
   Discussion opened by Dr. Jas. C. Sargent, Mllwaukee.
2. Clinic—Tumors Different Parts of Body.
   Prof. J. C. Bloodgood Baltimore.
3. "Differential Diagnosis Between Inflammatory and Malignant Lesions in the Chest".
   Dr. Byrl R. Kirklin, Roentgenologist, Mayo Clinic, Rochester.
   Discussion opened by
4. "Visualization of Oesophagus in Diagnosis of Heart Disease".
   Dr. Leo G. Rigler, Roentgenologist, University of Minnesota, Minneapolis.
   Discussion opened by

THURSDAY, MAY 28th, 6:30 P. M.

Banquet, Ball Room, Schroeder Hotel.

Toastmaster, Dr. Maximilian J. Hubeny, Editor of Radiology, Chicago.

Address—"What Every Doctor Should Know About Cancer in Every Part of the Body".
Prof. Joseph Colt Bloodgood, Johns Hopkins University, Baltimore.

FRIDAY, MAY 29th, 8:30 A. M.

1. Business Meeting.
   Address—"Organization."
   Dr. M. J. Hubeny, Chicago.
2. Diagnostic Technic.
   "Radiography of Lower Extremity".
   Dr. T. Sokow, Kenosha.
3. Round Table Discussion.
   Chairman, Dr. J. Newton Sisk, Madison.

Twelve Interesting Case Reports by Wisconsin Radiologists.

Governor Vetoes $55,000 Charge Upon Physicians; Also Medical Extension Appropriation

The proposal that Wisconsin physicians pay fifty cents each for the Wassermann, spinal fluid and blood sugar test now furnished through the Psychiatric Institute without charge, was vetoed by Governor La Follette the last week in April. The Governor also vetoed the appropriation of $5,500 for medical extension service but it was understood that funds will be appropriated from other sources to cover $4,300 of the $5,500 appropriation which is used to maintain the medical library service available to physicians throughout the state.

Upwards of 113,000 examinations for individual physicians in the state were made without charge at the Psychiatric Institute during the past year. Coming from the Finance Committee without notice, the budget bill of the state included the charge for fifty cents each as a means of financing the entire Psychiatric Institute laboratory service. In vetoing this portion of the state's budget bill, Governor La Follette made the following statement:

"There are few things that cause greater suffering and damage than social diseases, upon the innocent as well as the guilty. Twenty years or so ago Wisconsin embarked on a definite campaign for the cure and treatment of these diseases. Here is one point where statistics show a decided improvement in decreasing the number of inmates in our penal and charitable institutions because of this cause. The service provided by the Psychiatric Institute has been an important factor in the success of this important work. It would be a distinctly backward step, and a highly expensive one, for the State to place any obstacles in the way of the successful carrying on of this work."

VETOES MEDICAL EXTENSION

Under the apparent impression that the annual appropriation of $5,500 for medical extension was to cover only the cost of medical lectures, the Governor included this item as one that should be temporarily discontinued in order to bring the state's budget within the estimated income. In his comment on this section, Governor La Follette said:

"This appropriation was to cover the costs of medical lectures at various medical meetings throughout the state. It is a desirable service. It was recommended in the Executive Budget. It can be, if necessary, temporarily discontinued."

As result of conference following the veto, it is understood that while medical lectures may be discontinued for the two-year period, some arrangements will be made to maintain the medical library service with its appropriation of $4,300 annually. This service now fills upwards of 8,000 requests a year and it was pointed out that any suspension of the service with a suspension of journal subscriptions and collection of current literature would make it next to impossible to re-open the service two years hence. By reason of the state-wide nature of this library work, it is believed that means will be found through re-allocation of other University funds to maintain the service.

Thirty-Five Attend Secretaries' Conference in Milwaukee

Despite a blizzard that completely isolated portions of the state and delayed trains from other parts from one to six hours, thirty-five attended the Annual Secretaries' Conference held in Milwaukee on Saturday, March 28th. The Conference was opened by Dr. Otho

Fiedler, Sheboygan, President-elect, after Dr. W. G. Sexton, Secretary of the Wood County Medical Society had been elected to preside over the meeting.

Subjects of discussion at the Conference, most of which will appear in future issues of the Journal, included Care of the Indigent; What's New in Programs; Conception of Future Activities; A Social View of Medicine; Legislation and Public Relations of the County Medical Society. Speakers included Mr. F. M. Wylie, Deputy Attorney General of Wisconsin; Mr. Vernon Blank, Managing Director of the Iowa State Medical Association; Prof. John A. Lapp, Director Department of Sociology, Marquette University; Dr. E. A. Meyerding, Secretary Minnesota State Medical Association and Drs. R. C. Buerki, Carl Henry Davis, T. D. Smith, C. A. Harper and Mr. Crownhart, all of the State Society.

Those registered at the Conference included the following:

J. W. Prentice, Ashland
E. S. Knox, Green Bay
E. L. Bradbury, Neillsville
C. A. Armstrong, Prairie du Chien
L. V. Littig, Madison
G. J. Hathaway, Superior
P. G. Spelbring, Eau Claire
M. B. Glasier, Bloomington
A. J. Wiesender, Berlin
A. T. Gregory, Mauston
R. L. Eagan, La Crosse
W. B. Williams, Argyle
Verne E. Eastman, Wausau
Mr. Theodore Wiprud, Milwaukee
G. W. Krahn, Oconto Falls
I. E. Schiek, Rhinelander
Mr. George B. Larson, Frederic
Susan Jones, Racine
E. C. Hartman, Janesville
A. C. Radloff, Plymouth
R. L. MacCornack, Whitehall
J. F. Wilkinson, Oconomowoc
W. G. Sexton, Marshfield
C. A. Harper, Madison
Otho Fiedler, Sheboygan
S. D. Beebe, Sparta
F. W. Pope, Racine
R. C. Buerki, Madison
Carl Henry Davis, Milwaukee
E. A. Meyerding, St. Paul, Minn.
Mr. Vernon Blank, Des Moines, Iowa
Mr. Fred M. Wylie, Madison
Mr. J. G. Crownhart, Madison

The Society Sponsors a Summer Course in Obstetrics and Gynecology

In line with the newer emphasis given to obstetrics in programs of medical societies, and with its undeniable importance for the welfare of maternity and infancy, the State Medical Society of Wisconsin is joining with the University of Wisconsin in holding a summer postgraduate course in Obstetrics and Gynecology in six Wisconsin cities. The classes are open to physicians anywhere.

This project is part of a comprehensive state program for the improvement of general medical practice. The plan is admirably adapted to supplying instruction in the latest developments in medical practice, under the guidance of recognized specialists; and for many practitioners it offers a convenient substitute for a more expensive postgraduate course at a distant medical center.

The sponsoring organizations are the State Medical Society, the University of Wisconsin Medical School, and the University Extension Division.

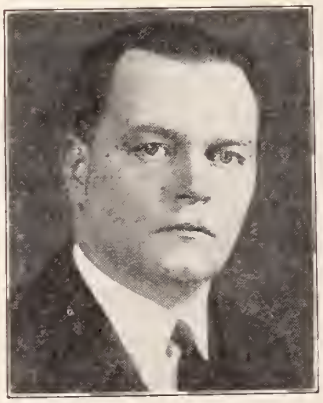
CENTERS IN SIX CITIES

The meetings for the instruction in Obstetrics and Gynecology will be held once each week (two hours) for twelve weeks, beginning June 15, 1931, in the following cities:

Appleton
Green Bay
Manitowoc
Marinette
Oshkosh
Sheboygan

Everett D. Plass, M. D.

The specific dates, hours, and places of meeting will be determined with reference to the desires of the greatest number of physicians registering. All members of the course will be informed well in advance concerning these local arrangements.


Otto H. Schwarz, M. D.

The instructional staff con-

sists of Dr. Everett D. Plass, Professor of Obstetricsand Gynecology at the State University of Iowa, Iowa City, and Dr. Otto H. Schwarz, Professor of Obstetrics at Washington University School of Medicine, St. Louis, Mo.

The topics for each of the twelve classes are as follows:

1. Management of Normal Pregnancy.
2. Complications of Pregnancy Including Abortion and Premature Labor.
3. Management of Normal Labor.
4. Management of Normal Puerperium.
5. The Toxemias of Pregnancy.
6. Puerperal Infections.
7. The Pelvis, Pelvimetry and the Contracted Pelvis.
8. Ante Partum and Post Partum Hemorrhage: Causes, Diagnosis and Treatment.
9. Obstetrical Analgesia and Anesthesia.
10. Forceps: Indications, Contraindications, Methods.
11. Management of Breech Presentations and Version.
12. Caesarean Section: Uses, Indications and Abuses.

Classes will consist of informal lectures and demonstrations, in some of which lantern slides and motion picture films will be used. There will be opportunity in each class period for informal discussions and questions concerning obstetrical problems and related topics.

LECTURERS EMINENTLY QUALIFIED

The visiting educators who will give this course have gained distinction in both the practice and teaching of obstetrics and gynecology. Dr. Plass is a graduate of Colgate University and of Johns Hopkins Medical School (1911). In 1914 he was assistant resident gynecologist at the Sloane Hospital for Women in New York City, and during the World War he served overseas with the Medical Department of the U. S. Army. Beginning in 1911, he was successively intern, assistant, and Associate Professor of Obstetrics at Johns Hopkins until 1922, when he became obstetrician-in-chief at the Henry Ford Hospital in Detroit. On July 1, 1926, he assumed his present position as professor and head of the Department of Obstetrics and Gynecology at the State University of Iowa.

Dr. Plass is affiliated with the following professional groups: American Gynecological Society; American Association of Obstetricians, Gynecologists and Abdominal Surgeons; Central Association of Obstetricians and Gynecologists (secretary-treasurer); Chicago Gynecological Society; Detroit Obstetrical and Gynecological Society; American Society of Biological Chemists (clinical member); Society of Experimental Biology and Medicine; Johnson County, Iowa State, and American Medical Associations; National Board of Medical Examiners; American Board of Obstetrics and Gynecology.

Dr. Plass has written numerous papers on obstetrical problems, and is the author of a textbook, "Obstetrics for Nurses," Appleton, 1923, and many more recent contributions to medical literature. He has conducted extension courses in obstetrics in eighteen centers in Iowa, Oklahoma, and Arkansas.

Dr. Schwarz is a graduate of Smith Academy, St. Louis, Mo., 1906, studied at Yale University, 1906-1908, and received the degree in medicine from the Washington University School of Medicine in 1913. He was intern and resident physician at Washington University Hospital and at Barnes Hospital, 1913-1915. Since then he has served on the faculty of Washington University Medical School in the following positions: Assistant and Instructor in Obstetrics and Gynecology, 1915-1921; Associate in Obstetrics, 1921-1922; Associate Professor of Obstetrics, 1922-1926; Professor of Obstetrics, 1926-1929; Professor of Obstetrics and Gynecology, 1929—.

Dr. Schwarz is affiliated with the American Association of Obstetricians and Gynecologists; the American Gynecological Society; Deutsche Gesselschaft für Gynakologie, St. Louis Gynecological Society; County, State, and American Medical Associations, and other professional groups. He has published many articles in the American Journal of Obstetrics and Gynecology, the American Journal of Surgery, and other publications.

REGISTRATION INFORMATION

The fee for the twelve weeks' course is $30. Applications may be made to Nelson D. Conners, field representative, University Extension Division, 314 University Extension Building, Madison.

This course is organized by the Medical Extension Advisory Committee, representing the three participating agencies. The members follow:

For the State Medical Society, Dr. O. A. Fiedler, Sheboygan; Dr. G. Gundersen, La Crosse; Dr. J. F. Wilkinson, Oconomowoc; Dr. M. D. Bird, Marinette; Dr. Karl H. Doege, Marshfield; J. G. Crownhart, Madison. For the Universtiy of Wisconsin Medical School, Dean C. R. Bardeen, Dr. R. C. Buerki, Dr. J. S. Evans, Dr. John W. Harris. For the University Extension Division, Dean Chester D. Snell, Chester Allen, Nelson D. Conners.

Questions of Basic Science Board for March Examination

Questions of the March examination for the Basic Science examinations are to be printed following each examination in the future, according to decision of the Board announced in a letter received from the Board this month. Questions of the March, 1931, examination are presented accordingly.

PHYSIOLOGY

1. Discuss briefly the physical processes which may be concerned in the passage of body fluids through membranes.
2. What are the factors concerned in coagulation of the blood?
3. What are the physiological mechanisms that bring about
   (a) Gastric secretion
   (b) Pancreatic secretion
4. What methods may be used to study the blood supply to various organs?
5. How does the body adjust itself to high altitudes?
6. What are the causes of muscular fatigue? Suggest some physiological measures for its relief.
7. Outline carbohydrate metabolism (including digestion and excretion).
8. Make the most important single statement you can about each of the following subjects: peripheral resistance, CO_2, hunger contractions, cerebral localization, optic chiasma, peristalsis, pressor nerves, complete heart block.

PATHOLOGY

Answer briefly, preferably in outline form, five questions.

1. What are the forms of pulmonary tuberculosis? Give their relations to one another.
2. Discuss pericarditis.
3. Define: Anemia; thrombosis; diabetes; inflammation; leukemia.
4. Cancer of the cervix: Type, gross description, and usual manner of spread.
5. Hydronephrosis: Causes, pathology and effect on patient.
6. Discuss embolism.
7. Give the pathology and complications of gastric ulcer.
8. Discuss chronic progressive lymph gland enlargement.

ANATOMY

1. Give the actions of the biceps muscle on the elbow joint explaining why it produces each action.
2. Discuss the anatomy of the heart from the standpoint of its function. Include nerves and general blood supply.
3. Discuss the anatomy of the stomach from the standpoint of its function. Include nerve and blood supply.
4. Give the general anatomical plan of the lymphatic system.
5. Show by a diagram the general distribution of a typical spinal nerve such as the 5th thoracic. Include its various nerve components showing their relation to the spinal cord, the lateral chain sympathetic ganglion, etc. (Be sure to make this diagram large enough and neat enough to be clearly interpreted).

DIAGNOSIS

1. What are the evidences of cardiac decompensation?
2. Discuss the significance of cyanosis in diagnosis.
3. What are the evidences of a lower motor neuron lesion?
4. What are the physical signs of pulmonary emphysema?
5. Describe and give the significance of the following:
   1. Argyll Robertson pupil.
   2. Cheyne-Stokes' respiration.
   3. Broadbent's sign.
   4. Ketonuria.
   5. Eosinophilia.
   6. Melena.
   7. Projectile vomiting.
   8. Hutchinson's teeth.
   9. Achlorhydria.
   10. Romberg's sign.

Medical Board Proposal Defeated by Joint Opposition of Homeopaths, Chiropractors, Eclectics and Osteopaths

Legislative Hearing on State Medical Society Proposal to Broaden Appointive Powers of Governor; Homeopaths and Eclectics Claim Protection Necessary

Hearing before Assembly Committee on Public Welfare on bill 345A, held in the Assembly Parlor in the State Capitol at Madison, Wisconsin, on the 18th day of March, 1931, 2:00 P. M.

Present: Assemblyman Don V. Smith (Chairman); Assemblyman Stephens, Assemblyman Sieb, Assemblywoman Charbonneau, Assemblyman Kellman, Assemblyman Penniston.

Chairman: Is Assemblyman Rowlands in the room? We will take up Bill 345A by Mr. Rowlands.

Before we open the hearing on this bill, I will say that we will have an adjourned meeting on this bill a week from today, so if anybody here appearing on this bill does not want to commit himself today, you will have another chance to be heard next Wednesday. We will have the hearing in the Assembly Parlor next Wednesday at the same time, on 345A. Those appearing in favor of this bill will now be heard. (No appearances in favor.) Those appearing in opposition to Bill 345A will be heard.

Dr. Elton: Mr. Chairman, my name is Dr. Edwin J. Elton, (O), of Milwaukee. I appear here today as opposed to the bill as it stands, but in view of the fact that I can't see any real object in making the change in this medical act as it now stands, I merely desire to register my objection and would like to be heard one week from today. Mr. Chairman, there are several representatives of the osteopathic profession here today, and I would like to ask each of them to rise and in turn and in very brief words state if they object to this bill. Dr. Heggen is President.

Dr. Heggen: Dr. E. S. Heggen, (O), Madison, Wisconsin. I wish to register as protesting against this bill.

Chairman: Is there anyone else?

Dr. Raymond: M. V. Raymond, (H), Chicago, representative of the Mid-West Homeopathic Institute, an organization of 29 states of the central and western United States. The entire organization wishes to register against the bill.

Dr. Bond: Dr. E. C. Bond, (O), Milwaukee. I wish to register as being opposed to the bill.

Dr. Jackson: Dr. J. R. Jackson, (O), of Milwaukee. I wish to register as opposed to the bill.

Dr. Davis: Dr. Ralph B. Davis, (O), of Milwaukee. I wish to register as opposed to the bill.

Dr. Young: Dr. J. R. Young, (O), Beloit, Wisconsin. I wish to register as opposed to the bill.

Dr. Logan: Dr. J. A. Logan, Madison. I wish to register as opposed to the bill.

Chairman: Anyone else?

Dr. Bullis: Dr. H. R. Bullis, (O), Milwaukee. I wish to register as opposed to the bill.

Dr. Noordhoff: Dr. L. H. Noordhoff, (O), Oshkosh. I would like to register as opposed to the bill.

Dr. Jones: Dr. L. A. Jones, (O), of Janesville. I would like to register as opposed to the bill.

Dr. Chase: Dr. Estelle Chase, (H), of Fort Atkinson. I wish to register as opposed to the bill.

Dr. Radtke: Dr. C. W. Radtke, (O), Ashippun, I wish to register as opposed to the bill.

Dr. Frey: Dr. R. A. Frey, (O), of Oshkosh. I wish to register my opposition to the bill.

Dr. Kerr: Dr. J. D. Kerr, (O), Fond du Lac. I wish to register my opposition to this bill.

Dr. Johnson: Dr. H. T. Johnson, (O), of Appleton. I wish to register my opposition to this bill.

Dr. Harned: Dr. L. B. Harned, (O), Madison. I wish to register my opposition to this bill.

Dr. Rogers: Dr. John E. Rogers, (O), Oshkosh. I would like to register my opposition to this bill.

Dr. Purdy: Dr. V. W. Purdy, (O), Milwaukee. I wish to register as opposed to the bill.

Dr. McCormick: Dr. J. J. McCormick, (O), Sheboygan. I am opposed to this bill.

Dr. Baxter: Dr. M. V. Baxter, (O), West Allis. Opposed.

Dr. Harned: Dr. J. J. Harned, (O), Madison. I wish to register as opposed to the bill.

Dr. Breitzman: Dr. E. J. Breitzman, (O), Fond du Lac. Opposed to the bill.

Dr. Housel: Dr. L. J. Housel, (O), Madison. Opposed to the bill.

Dr. Berry: Dr. J. A. Berry, (O), Hustisford. Opposed.

Dr. Sannes: Dr. C. R. Sannes, (O), Madison. Opposed to the bill.

Dr. Gieselman: Dr. J. Gieselman, (O), Madison. I would like to make my protest to this bill.

Dr. Johnson: Dr. A. W. Johnson, (O), Neenah. Opposed to the bill.

Dr. Kosanke: Dr. F. E. Kosanke, (H), Fond du Lac, Secretary, Wisconsin Homeopathic Medical Society. We came here to try to find out what the reason is for posting this bill, because we see no reason for it.

Dr. McKnight: Dr. G. B. McKnight, (H), Fond du Lac. Health Commissioner of the City of Fond du Lac. Opposed to the bill.

Dr. Remer: Dr. W. H. Remer, (H), Chaseburg. Opposed to the bill.

Dr. Alexander: Dr. W. S. Alexander, (H), Fond du Lac. Opposed to the bill.

Dr. Holtz: Dr. H. M. Holtz, (H), Beaver Dam. Opposed to the bill.

Chairman: Any others opposed to the bill? I want it understood that any of those that can't come to the adjourned meeting next Wednesday can still be heard at this meeting on this bill. If there is no one else opposed to the bill, we will close the hearing on this bill and take up Bill No. 148, S.

Others registered were:

For the Bill: Assemblyman E. M. Rowlands, Cambria.

Against the Bill: B. W. Purdy, (O), Milwaukee; Assemblyman Stanley M. Slagg, Edgerton.

SECOND HEARING

Hearing on bill 345A before Assembly Committee on Public Welfare, held in the Assembly Parlor in the State Capitol at Madison, Wisconsin, on the 25th day of March, 1931, 2:00 P. M.

Present: Assemblyman Don V. Smith (Chairman); Assemblyman Stephens, Assemblyman Sieb, Assemblywoman Charbonneau, Assemblyman Kellman, Assemblyman Penniston.

Chairman: The Committee will come to order. We will take up Bill No. 345, A., by Mr. Rowlands, a bill to amend subsection (1) of Section 147.13 of the statutes, relating to the state board of medical examiners. Those appearing in favor of the bill will now be heard.

Mr. Crownhart: Mr. Chairman and members of the Committee. George Crownhart, Secretary of the State Medical Society. Before I go any further, Mr. Chairman, may I interrupt long enough to say that I am most appreciative of this Committee postponing the bill for one week. Two days before the last meeting I was called to Janesville by the very sudden death of my brother-in-law, aged 37, and it was just simply impossible for me to be here. I am most appreciative to these people who made the return trip. I know it was at a cost of time and money, and I do want to thank them for that courtesy.

Mr. Rowlands has introduced this bill for the State Medical Society. Before going into the bill proper, may I explain from a layman's viewpoint one or two terms, so we will have no confusion. You will note in the laws relating to the appointment of the State Board of Medical Examiners that there are four terms used: allopathic, homeopathic, eclectic and osteopathic. I might say I am not trying to give a scientific definition of any difference that exists, but I shall outline some definitions which we will have as a working basis as we go along on the bill, and I am perfectly willing to be corrected at this time or any other time.

The allopath is the non-sectarian practitioner. The homeopath agrees with the allopath in all points except that basically they believe that diseases are curable by those drugs that produce effects like the symptoms, and that the effect of drugs is increased by giving minute doses. The eclectic has as his motto the words, "I choose", and is said to select from any system that which he believes best for the patient, and in that he is truly non-sectarian. At one time, at least, they had the belief that those remedies secured from plants were more effective and better than those prepared chemically from other substances than those of plant life. The osteopath, of course, believes in manual manipulations as a method of maintaining the structural integrity of the body.

Now, the purpose of a State Board of Medical Examiners is solely one, and that is protection of the public against any physician who might otherwise be licensed without proper qualifications. That is the sole purpose of any state board of medical examiners. The Wisconsin Board was created in 1897 with 3 allopaths (non-sectarians), 2 homeopaths and 2 eclectics; and then in 1915 when osteopathy was recognized in Wisconsin, one osteopath was added to the Board. So we have at the present time a board of 8 members composed of 3 allopaths, 2 homeopaths, 2 eclectics and one osteopath. I mean by that they must have graduated from homeopathic, eclectic or osteopathic schools to be qualified for appointment under those designations in the law. At the time of its creation in 1897 the Board had separate examinations for homeopaths and eclectics. The homeopaths would be examined in the materia medica as taught in the homeopathic schools; the eclectic by his members of the board; and at all times since the osteopath has been on the board, applicants for licenses to practice osteopathy and surgery have been examined in the principles and practice of osteopathy by the osteopathic member. In the original law the State Medical Society submitted the lists from whom the Governor made his selections of non-sectarian practitioners; the State Homeopathic Society, when appointments were due in the homeopathic field, would send in a list of names, and the State Eclectic Society for their two.

Now, so you will know what the situation is today, I have some charts I will distribute to members of the Committee. In the first place, I have a graph on top (Table I) that shows the number of physicians licensed in ten years, 1920 to 1930. In the non-sectarian group you will see that 1019 were licensed in that period. In the homeopathic group you will notice that 8 were licensed; and in the eclectic group, 1. These figures were obtained by taking the list of those licensed in Wisconsin in the last ten years and checking back each individual to see what college he graduated from, according to the information furnished us by the Board of Medical Examiners. Osteopaths numbered 77 in the 10-year period.

Now, when you take the second part of the graph —those now in practice in Wisconsin, you will notice that as nearly as we can figure there are 2817 non-sectarian practitioners in the state; 139 homeopathic, as nearly as we can ascertain by taking the American Medical Association directory and checking back on each member to secure the school of graduation; and 44 eclectic—this number is reduced materially when we take those under the age of 70. Osteopaths in the state—I have not any accurate figure; according to my best estimate it is between 85 and 100. If I am wrong I know they will correct me.

On the second table you will find the Medical College Graduates for the period of 1901 to 1930. And you will notice in the last five years, in the last column, there were 20,000 non-sectarian graduates; 566 homeopathic; 220 eclectic; 45 miscellaneous.

TABLE I

MEMO ON BILL 345 A

I PHYSICIANS LICENSED IN TEN YEARS 1920 - 1930

Non-sectarian (so-called allopath) - 1,019

95 9/10 %

Homeopathic - 8

7/1000 %

Eclectic - 1

8/10,000 %

Osteopaths - 77

3 3/10 %

11 PHYSICIANS AND OSTEOPATHS NOW IN WISCONSIN

Non-sectarian - 2,817

95 6/10 %

Homeopathic - 139 (100 under age of 70)

4%

Eclectic - 44 (28 under age of 70)

1 1/10 %

Osteopathic - Approximately 100

3 3/10 %

And if you will turn to the third table of Medical Colleges, you will note in 1901, four years after the law was enacted, there were 125 non-sectarian colleges, 22 homeopathic colleges, and 10 eclectic colleges. And then if you carry over across the column to the year 1930 you will note the non-sectarian number 74; the homeopathic, 2; eclectic, none.

And then in the fourth table you will find a complete set of statistics so far as number licensed in

Wisconsin from 1904 to date, and that is as far back as we could go to secure the figures.

TABLE II

MEDICAL COLLEGE GRADUATES

	1901–05	1906–10	1911–15	1916–20	1921–26	1926–30
Nonsectarian ..	24,791	22,078	18,547	14,111	19,863	20,439
Homeopathic ..	1,790	1,118	895	646	462	566
Eclectic	734	621	420	243	209	220
Physio - Medical	100	76	5	..	..	..
Nondescript ...	83	147	..	270	305	45
Totals ..	27,498	24,040	19,867	15,270	20,539	21,270

TABLE III

MEDICAL COLLEGES

	1901	1905	1910	1915	1920	1926	1930
Nonsectarian	125	125	109	83	76	74	74
Homeopathic	22	19	12	9	5	2	2
Eclectic	10	9	8	4	1	2	..
Physio-Medical	2	3	1	..	..	..	..
Nondescript	1	2	1	..	3	1	..
Totals.....	160	158	131	96	85	79	76

TABLE IV

LICENSURE IN WISCONSIN SINCE 1904

	1904–05	1906–10	1911–15	1916–20	1921–25	1926–30
Nonsectarian ...	140	290	309	189	342	677
Homeopathic ...	6	8	3	4	1	7
Eclectic	..	1	1	..	..	1
Physio-Medical .	..	..	..	..	..	..
Nondescript	..	..	..	2	..	3
Totals ...	146	299	313	195	343	688

Total for 26 Years

Nonsectarian	1,947
Homeopathic	29
Eclectic	3
Physio-Medical	..
Nondescript	5
	1,984

Now, it will be interesting to note how these men that are presently in the state are scattered throughout the state. In Jefferson County Assemblyman Smith has one eclectic and two homeopaths. In Grant County Assemblyman Stephens has one eclectic and two homeopaths. For Assemblyman Kay there is one eclectic. And for Assemblyman Sieb there are no eclectics in his district, and only one homeopath. In Douglas County Mrs. Charbonneau has no eclectics and no homeopaths. Mr. Kellman in Trempealeau County has no homeopaths and no eclectics. And Mr. Penniston in LaFayette County has in his district no homeopaths and no eclectics.

Now, I think it is obvious that these men now licensed in the state need no protection from this board or any other board. That was not the original purpose of the board, and it is not now. They are licensed in the state, and the Board of Medical Examiners have nothing to do with them from now on, unless their license should be revoked, and that would follow only upon conviction of some major offense in court.

In the second place, I think it will be admitted that in recent years there have been no separate examinations in the subject of materia medica for either homeopaths or eclectics. The homeopathic schools are represented in the Association of American Medical Colleges and they are given full recognition. Their students study regular materia medica, and as I understand it have their homeopathic course in addition. Their graduates take the regular examination in Wisconsin.

Now, the difficulties in making appointments which led to the proposed bill before you were these: In 1925 Governor Blaine found that these lists from the several State Societies so restricted him in his appointments that he asked for their repeal. Such a bill was introduced by Dr.—then Senator Barber, and was carried through both houses of the legislature without any opposition. At the present time, despite the fact that the Governor no longer has to choose from lists, he has this situation: There are 8 appointments, 4 expiring every two years. Naturally, outside of possibly having two appointments in Milwaukee because of the large number of physicians in Milwaukee, he does not desire to duplicate territory already represented. Very naturally he does not wish to appoint anyone on the board that has been active politically against him. He must appoint some one in whom he has confidence and trust, if we are to avoid such a situation as occurred in Connecticut. He will find some who feel they cannot give the time, and he will find some that will not serve. That narrows the list that is available to him of strictly eclectic or strictly homeopathic graduates to a very small and restricted few. It was this situation that caused the House of Delegates of the State Medical Society to propose the present bill to the legislature. It was proposed and adopted by the House of Delegates in 1928, with the thought that it would be proposed in the 1929 session of the legislature. We were asked to postpone it two years to see if the number of homeopaths in the state did not increase. We were very happy to accede to that request. They have not increased—one in 1929 and one in 1930. I mention that only to show that the bill has no political aspect whatsoever. We proposed it, so far as the Society was concerned, when Kohler was Governor.

The bill shortens no terms of present board members, if you will notice the last paragraph of the bill. We do not ask that any present member of the board shall have his term shortened. The bill excludes no one from appointment. It simply provides, instead of 3 allopathic, 2 homeopathic and 2 eclectic appointments as such, that the Governor shall appoint seven licensed to practice medicine and surgery in addition to the one osteopathic member, provision for which remains unchanged. So far as the State Medical Society is concerned, we are perfectly willing that if the Governor sees fit he might appoint four eclectics and three homeopaths if he may choose them as representing the best in the medical profession of Wisconsin and not as representing classes that, to our mind, have long since disappeared. We are willing in this measure to give the Governor the widest possible choice to the end of obtaining the best in the public interest.

The opposition to this bill comes from two sources in addition to that of the State Board itself, and

each must be considered separately. The opposition presented by some homeopaths and eclectics is partly based upon sentiment. We have recognized that and appreciate it, and give it its due weight. And then there is the question, Will they have a possible building program? We admit they probably do ahve that program, and possibly it will be carried into force, but we doubt whether the two homeopathic schools will go farther than will the total group of 74 non-sectarian schools. Then there is their argument that there should be no majority on the board for any school or sect. That may have been fair in 1897, when each group was having its own examinations and when differences between the two schools, or three schools, were very much in evidence. We simply cannot believe that it exists today, nor that they would wish it to exist. So far as fairness of the board is concerned, they are all taking the same examination, and we have seen no evidence in recent years that there is any such feeling. Twenty states and four territories have a law similar to that that is before you now.

Then there is the osteopathic viewpoint. I understand it has been said that if there is a board composed of seven licensed to practice medicine and surgery and only one licensed to practice osteopathy, that the seven will control the board and that there will be discrimination against the osteopathic members. I have seen no evidence of it as the board now exists, and now to say that it would exist, is to pre-judge the men this Governor or any other Governor might appoint to the board. I will say this: that if this bill should be adopted, at any time they can show that discrimination, unfairness or partiality has existed, personally I will place no objection in the way of having anything possible done to remove it. I do not believe that it will ever exist.

Now, there are no osteopaths on six state boards that license osteopaths. The osteopath is called in to assist in the examination in four other states, and in three states the osteopath is in the minority on the board, as he would be and is, in this state. This bill thus follows the present practice in thirteen states. I think the Governor's appointees, whoever they may be, will be fair, and I proceed on that assumption.

Now, one other thing. I tried to advise those homeopaths and eclectics who are members of the State Medical Society,—and about half each group that are residents in the state are members of the State Society,—of the terms of this bill. I tried to do it fairly, and offered to send the bill and did send the bill in a great many instances. I have as a result of that many voluntary letters that indicate that many of the homeopaths and many of the eclectics,—I will say 10 or 15 of each group,—favor the proposed bill; not alone on the basis of that letter, because I sent the bill, so that they know exactly what it is pending here. I have one letter that came from an eclectic who graduated from and subsequently taught in an eclectic school, in which he says he feels that no reason exists for placing any restriction upon the power of the Governor to select those whom he considers best fitted to fill positions on the Wisconsin State Board of Medical Examiners. Another that says that he sees no need to continue the board as it is, inasmuch as all now take the same examination. And still another says —these being all in the eclectic group—that he feels it is more of a sentimental rather than practical consideration at the present time. And one homeopath in Mr. Stephens' district says he thinks we should seek only to place the best men obtainable on this board from the public viewpoint, without respect to schools of healing.

Now, I think it will be admitted by all that the two men in Wisconsin that have always tried to advise the legislature and advise the State Medical Society from the point of view of a disinterested person looking to the public welfare, are the deans of the two medical schools in this state. I would like to file with the Committee copies of letters from Dr. Bardeen and from Dr. McGrath, Deans of the University of Wisconsin and Marquette Medical Schools, in which each favors the present bill after having seen it. And so that those appearing in opposition may have an opportunity to know the contents, I would like to read these letters. This is Dr. Bardeen's letter:

"I am in favor of the proposed change in the law relating to the State Board of Medical Examiners. I have no complaints to make of the present Board so far as our students are concerned. I believe, however, that the Board of Medical Examiners should be looked at, not from the point of view of the welfare of our own or any other medical school, but from that of the public. The public should look to the Board of Medical Examiners to put its stamp of approval on men competent to practice medicine along modern lines. When a man is licensed to practice medicine, he should give every evidence of being worthy to be entrusted with the responsibility of directing the care of the sick. The Governor should not be hampered in the selection of those men whom he believes best qualified to judge of the fitness of those whom the State is to approve as qualified to practice medicine. There is no need any longer of trying to protect special sects. There are no longer any eclectic schools. There are only a few schools of homeopathy, and these schools are recognized as on an equality with the other good schools, and their faculties, students and graduates are treated by the non-sectarian schools on the basis of full equality."

Dr. McGrath states in one paragraph: "This is to inform you that I approve of Bill Number 345, A., in its present form. Obviously, the sole purpose of such a law should be to secure the best possible board members with the single viewpoint of public protection. The present limitations on the Governor conduce to limiting and restricting unnecessarily a choice that should be as broad as possible in the public interest. I am convinced that this

bill is a substantial step forward in progress, and is therefore a sound basis for perhaps further improvement."

Now, Mr. Chairman, I think that this bill that is before you presents the best thought of the House of Delegates of the State Medical Society,—a body composed of representatives from every county in the state, who adopted the proposal that is before you without a dissenting vote, and which proposal was seconded in that House by a homeopathic member. If you wish free choice of appointive power to secure the best Board in the general interest you will pass this bill. Opposition can only be justified on appeals narrowly based that would place unnecessary favors to a few above the broad principles upon which the law was founded.

Inasmuch, Mr. Chairman, as I think I am probably the only one to appear—our only interest being to place the information before you—with your permission, I would like to reserve one or two minutes at the end, if something comes up that I should like to re-present. Thank you.

Chairman: Does the Committee wish to ask Mr. Crownhart any questions?

Mr. Crownhart: I will be very happy to answer any questions.

Chairman: Anyone else wishing to appear in favor of the bill? If not, we will close the hearing on those appearing for. Those opposed to the bill will now be heard.

Mr. Walter D. Corrigan (Milwaukee): Ladies and Gentlemen of the Committee. I appear as the legislative counsel in this particular matter for the Wisconsin Osteopathic Association, for which Association I have been the regular attorney for some 15 or 16 years. My name is Walter D. Corrigan; my residence is R. R. 2, Cedarburg, Wisconsin.

You have already learned that there are four schools of healing that are affected by the provisions of Section 147.13 of the statutes, which is the section which by this proposed measure it is proposed to amend. They consist of the allopathic school of healing, the homeopathic, the eclectic and the osteopathic. Any other schools of healing of any type or character whatsoever are not included within the provisions of this law, and are therefore not, I suppose, to be considered in any discussion of this question.

We frankly concede that the allopathic school has a great many more practitioners than any of the others, and I have no dispute with counsel for the Medical Society on the subject of his numbers. Besides that, I am not interested in numbers. I am here interested in certain principles which are not involved at all in any count of numbers. The first three of these schools of medicine are those that are engaged in the practice of medicine and surgery under the provisions of the Wisconsin law which has existed in substantially the same form since about 1915. I think, to be exact, it was 1915, though it has been amended in slight particulars since. The one which I represent are those who are licensed to practice osteopathy and surgery under that same law. That, you see, divides those who are in these respective schools of healing into two classes; those who have a license to practice medicine and surgery, and those who have a license to practice osteopathy and surgery.

This is not the first time in the history of this state that a suggestion has been made which, according to my view and in view of the history arising shortly after the creation of the law of 1915, involved a disposition which to my mind is contrary to the public welfare,—to have a board created and have it capable at least of being so controlled as to act with excessive power and be in a situation where it could act with great arbitrariness. In fact, we have had in the history of this matter within the last fifteen years an instance of the most arbitrary action that I think I have ever discovered in my professional career of 35 years. And I mean to bring it home to you here today, not because I wish to open up any old sores, but because I want to use it as an illustration of what is possible to be done by a board under a law which for any reason becomes unbalanced between or amongst these various schools of healing.

The law of 1915 plainly and unambiguously, after great deliberation and very considerate thought upon the part of the legislature, provided these two forms of licenses that I have told you about. And the board being then unbalanced, not because of any such suggestion as is made here but being unbalanced between these two divisions known as "medicine and surgery" and "osteopathy and surgery", proceeded in the most arbitrary manner to interpret the statute absolutely contrary to its plain and unambiguous provisions. And the Board in regular session, notwithstanding the plain purpose of the legislature,—so plain that when the Supreme Court came to pass upon the matter they said there wasn't any chance for argument, arbitrarily setting themselves up against the law and against the judgment of the legislature and the judgment of the Governor who signed the bill, proceeded to deny to those who graduated from the schools of osteopathy and surgery the right to take the examination in surgery. And notwithstanding the law provided for the giving of a license to practice osteopathy and surgery as one license, they proceeded to permit them to be examined only in the subjects other than surgery, notwithstanding their education was in compliance with the requirements of the law; permitting them to take the examination only in question of osteopathy, and denying them the right to take the examination in surgery, and wouldn't license them for anything except osteopathy, when there was no provision in the law for any such license at all.

I don't wish to go back to those old quarrels, but it does fasten this responsibility upon this legislature to which this appeal is made; it shows what an unbalanced medical board can do; it shows what power it has; it shows the danger of that power;

it shows how, because it is unbalanced, it can be arbitrary and unreasonable and unjust, and can act so as to be repudiated by the Supreme Court of the State, who practically suggested to them that they hadn't been able to read the plain English language. As a result of their rulings covering a period of five years, in which they kept the graduates of the schools of osteopathy and surgery from taking the examination in surgery in this state, the osteopathic profession, complying in every way with the provisions of the law and their schools having risen to the highest standards on the subject of surgery in this country, were obliged to bring what is known as the case of State ex rel. Pollard against the State Medical Board, reported in 172 Wis. at 317. And as a result of that case the arbitrary action of this Board, absolutely contrary to the plain language of the statute, was condemned by the Supreme Court, and they were compelled by a writ of mandamus issued by the Supreme Court of this State to permit those graduates to take the examination in surgery. After that case was decided, and it was decided at a time when it wasn't possible to have an examination in surgery for about five months, they proceeded in the next five months during the session of the legislature of 1921 to try to get the legislature of this state to repeal and annul the decision of the Supreme Court by having the legislature annul and deny to the graduates of those colleges the rights which had existed for five years, and which they had arbitrarily and unjustly denied. And that same board that was unbalanced at that time, that acted in that unjust and unreasonable way, were the promoters of proposed legislation which received a condemnation at the hands of the legislature because their acts were manifestly unjust and unreasonable over a period of five years.

Now, what was the result of all that? The result of it was that through the changes that were made in the course of time in the medical board of this state under the present law,—though that board had been unbalanced and though the different schools of medicine had combined at that time in that way against the osteopaths, it came to be in the course of time a balanced board of broader and more liberal men; it got away from the narrow ring that had controlled it before; it got to the point where it ceased to exercise arbitrary powers and came to act upon justice and reason. And the result has been that shortly after that illegitimate attempt to get the legislature to annul the decision of the Supreme Court, this board came to be a balanced board with all its checks and balances between the different schools of healing. And the result was that the men of the various phases of the medical profession,—the allopathic, the homeopathic, the eclectic, and those representing the other school of healing that I represent, came together, which resulted in coordinate legislation which they all fathered for the benefit of the public, which resulted in the passage of such laws as the basic science act, through the coordinate influence of all. And this board indeed became a board that had all the checks and balances providing for safety and against the arbitrary action of power or use of power; and it became just and considerate and reasonable, and respected the law and respected the rights of all,—and more than all, it respected the rights of the public, which counsel has frankly conceded here to be the fundamental, the primary rights in any event, as distinguished from the individual rights of practitioners or the representatives of individual schools. The result is that we have a situation in Wisconsin, so far as the medical board is concerned, where it is just, honest and right and straight and clean as between these different schools of healing. Nobody can fairly or justly complain of it. Everybody is given considerate treatment. The interests of the public are protected.

And now we have a new plan that must have originated in the brain of some of those fellows who participated in that arbitrary action many years ago, in 1915 and 1916 and continuing down to 1921, by which they proposed to destroy the efficiency and just provisions of this law which creates a system of checks and balances between the various schools of healing and gives them all representation on the board, and more than all,—indirectly provides that no school of healing shall have a majority on this board, which is the real dangerous thing about this proposed act. The minute you give one school of healing a majority of the board, so that they control it; and just the moment that some Governor of this state makes a mistake and chooses somebody so that a majority of the board may be built upon narrow standards and may think that their particular school of healing is the only one that is entitled to exist under the state,—just that moment you introduce the opportunity for arbitrary action, just like existed and resulted in the situation which led to the Pollard case.

It is to be observed that many of the states of the union have created separate boards, one board that deals with the subject of giving licenses for the practice of medicine and surgery, another board that deals with the subject of issuing licenses for the practice of osteopathy and surgery. That is one solution of possible trouble. But we don't need that in Wisconsin. We don't need it because probably there will never be a repetition of anything like that which led to the trial of the Pollard case. Even though it happened under a board, in a way created in similar manner to the board now, it wouldn't happen again because of the lessons that were learned in that case, unless the legislature of this state in some way gives one of these schools a majority. And if it does give one of these schools a jority. And if it does give one of these schools a majority, you may expect bigotry to prevail, for it isn't any more out of the medical profession generally than it is out of the churches, notwithstanding

the great blessings of our fundamentalism teaching us that all should be treated alike and that we should have equality before the law, and that we should all have the right to worship God and think and speak upon every question according to the dictates of our conscience. I say that with the harmony which exists today through this balanced board of medical examiners, Wisconsin needs only one board; but it does need in the creation of that board the protecting care and the fine judgment of the legislature to the end that it shall not become unbalanced.

The very purpose of this law is manifestly to correct any danger of arbitrary conduct. Its very purpose is to create checks and balances. It is akin to the very principle that we have followed in this state in respect to the selection of judges of the Supreme Court, to keep them selected from different parts of the state, for one thing; and from the different political parties and affiliations, for another thing,—so that upon that great court there shall always be checks and balances against the arbitrary action of anybody that may have a majority and be building upon narrow lines. I want to submit to you that in the whole history of the world, and particularly in democracies, there has never been anything so dangerous to the welfare of human society as the granting of too much power to a single individual or to a single board. It has always resulted in despotism. You may choose the finest king in the world, and give to him the power of a king; and he may be the finest character in the world and it may be that under him you may have the best government there is in the world; but the creation of that power is dangerous,—that king may lose his head, just the way some of these long-time judges lose their heads that are appointed to the Federal bench. They may go on there as the finest judges in the world, and turn out to be the most arbitrary, because protected by an appointment for life they have come to abuse power. And so if there is anything in the principle of democracy, and I believe there is,—I have the greatest confidence in that, I believe in a democracy being spelled all in capital letters all the way through; and if there is anything that protects the safety of democratic institutions, it is the judgment of a legislature which creates power with checks and balances so that no one shall ever be permitted to abuse it. We saw an exhibition of this arbitrary power in the history of the case I have mentioned.

Now, what does harmony do on a board of this kind? Do you know that as a result of the harmony that came about after that long battle was over and after the pipe of peace was smoked,—and I refer back to this with a good deal of pride—do you know that the representatives of all these different schools met together and harmoniously went over the whole program in making a fine effort to raise the standards in all the schools of healing in this state so as to protect the public? That shows what a harmonious board can do, a board that has its checks and balances to protect against the use of arbitrary power; and it was as a result of that that the basic science law was passed, and many other things have been done in respect to the raising of standards in all the schools of healing.

Now, I say with counsel on the other side that the matter of chief concern with respect to a matter of this kind is the protection of the public welfare and the public health. And I say in addition that if we are going to have the public health in mind and have the public welfare for our concern, we must see to it that no law is passed which enables anybody to create or manipulate a ring; because in ring rule we never have very much concern for the public welfare. And I would add to counsel's chart a longer black mark than he has got on it. He has a black mark on there that indicates the number of allopathic, number of homeopathic, number of osteopathic and the number of eclectics. I would put a black mark on there that is longer than any of them, and that would be a black mark that shows the concern we have for the public welfare and the public health in Wisconsin. I say that the law shouldn't permit any school of healing—whether allopathic or homeopathic or eclectic or osteopathic or any other new one that may arise, and we may have even better ones arise in time to come—I say that no board should permit any one of those to be in a position where they can dominate, and that it is dangerous to let any such situation arise. I say that you shouldn't pass any legislation which will afford the least tendency to establish a closed shop in favor of the practitioners of any particular school of healing.

I don't know whether counsel intended to imply that this was an administration measure or not; but in any event I know that it isn't. And it couldn't be. The only thing that is really fundamental in respect to a movement of this kind concerning a bill of this kind, the only real fundamental that lies underneath this whole proposition is the fundamental that I have asserted,—that the law should create checks and balances so as to preserve against the danger of arbitrary action. I will concede that this present administration, which I love and respect as much as any man in the state, would if it had time to consider this subject be fundamentally right in the position that I assert, and it couldn't be otherwise in view of the history of the La Follette family. I know what that history is, and I know what its fundamentals are. A philosophy of government that is based upon the theory that all men have a right to live in human liberty and to pursue happiness in a government that is conducted by the consent of the governed, in which an excess of arbitrary power is denied, in which every citizen shall be a member of a governmental partnership and everybody shall be equal before the law, and that special privileges shall always be denied to anyone who seeks them. And that philosophy cannot coordinate with the principles of this bill. It don't square with the democratic prin-

ciples upon which this United States of America is founded. They have argued here in one breath that they seek no majority of the board, and then they turn about and argue that it would be right for those who have the greatest number in the profession of healing in this state to have a majority. They did it right here. I am saying that it is neither right that they should have a majority because they have the greater number, because that is a consideration which is not involved in a consideration of the public welfare; I am saying that it is wrong that they should have a majority, because the majority of one single school as against the other three can exercise arbitrary and dangerous power which undermines the very fundamentals which are behind a measure of this kind. Here we have a medical board today that, as I understand it, stands unanimously against this bill. They know how that board is working even better than the Medical Society of the state,—working in harmony for 10 or 15 years now, in perfect harmony, 10 years at least, solving all these questions, doing justice to every school of healing and at the same time doing justice to and protecting the people of Wisconsin. And then they propose to come along here with a measure which will unbalance that balanced board, and in the hands of any Governor now or one to come may result in the selection of a majority of one particular school of medicine.

Counsel has admitted here in so many words that there is no unfairness now with respect to this board. I say that there is no unfairness now, because we have a balanced board, which has come to during the last ten years and found out that the best way to promote the interests of the people of Wisconsin and the public health is to work harmoniously together.

Now, those are my views, ladies and gentlemen of the Committee. They are based upon a good many years of consideration and thought on this question that arose out of that hard battle that cost the members of the honored profession that I represent as a lawyer a whole lot of money, a whole lot of patience, a whole lot of forgiving, in order that they might attain the plain and unambiguous rights which the legislature had granted them and which an arbitrary medical board that existed at that time unjustly denied them, and unjustly denied them to such an extent that the Supreme Court said in its opinion in the 172d Wisconsin that the matter was so plain that it even didn't justify argument. Thank you.

Chairman: Any questions the Committee would like to ask at this time? Anyone else appearing in opposition to this bill?

Mr. Brody: Lawrence Brody of La Crosse, legislative counsel for the Wisconsin Homeopathic Medical Society. Gentlemen: I have listened with a great deal of interest to the argument of the counsel for the State Medical Society of Wisconsin, and I can understand his point of view to a certain extent, in the same way that I can understand the point of view of the Society itself, and in the same way that I can understand the point of view of every other school of healing that exists in this country. There is something ingrained in our nature that requires us as children and as young men and women to pay particular attention to what our school teacher has told us, and I can remember the principles that my teacher laid down to me when I was a boy and told me they were true, and all the stages of time could never convince me that they were wrong,—I just can't bring myself to believe that my teacher could be mistaken.

And in this country we have the allopathic, and we have the homeopathic, and the eclectic, and now the osteopathic, and many other schools of treatment. And you gentlemen are experienced, and you know that as a general thing there isn't a member of any one of those schools of healing that has any toleration or any consideration whatever for the teachings and the philosophy of the other schools. You take your chiropractor,—he doesn't believe that your allopath is anything but a fakir; and your allopath doesn't believe, if he talks confidentially to you, that anybody practicing any other school of medicine is anything but a fakir. But the public stands out here in the center somewhere and decides who they go to when they are sick. And some of us believe in the allopath; and some of us believe in the osteopath; and some of us believe in the homeopath. But we all ought to be big enough to realize that the one big thing to be considered by this legislature or to be considered by any other body that passes upon such a question is the right of the sick man to get well in the manner that he thinks will best make him well.

Now, there isn't any dispute, and I am sure that Mr. Crownhart wouldn't disagree with me, when I say that many of the most learned men in the world are the firmest believers in the homeopathic system of healing. I am not going to try to explain the difference, because I frankly confess that I cannot understand all the differences. They are too deep for a layman to understand; and if they were to be explained, I take it that it would hustle some allopaths to explain exactly the theory and the philosophy of the homeopathics, and vice versa. We do know that some of the biggest hospitals in the country, and there are now some 40 of them, and some of the best endowed hospitals in the country are using the homeopathic methods exclusively. We know that the President's own physician,—the President of the United States—is a homeopath. So is the personal physician, by the way, of the Prince of Wales. And we do know that in Germany today they have established a chair of homeopathy in the University of Berlin, and are establishing another one at Frankfort; and the German people, as you know, have been foremost in the study of medicine for centuries. So that all we can say, as reasonable men and women, is that there must be some merit, not only to one of these schools; there must be a good deal of merit to all of these schools, and if

there is a good deal of merit to all of these schools then I know that not one of you or any other member of this legislature wants to deprive me of the right to go to that person that I think may make me well, if he is competent and qualified in his particular school.

Now then, I charge that is the purpose of this bill,—to take away from me the right to consult the physician that I want to go to. And you take away from my children and those that come after me the right to go to the school of healing that they want to go to to be cured. And if that isn't true, gentlemen, why do they suggest this? Oh, they say the allopaths are out of number to the eclectics and the homeopaths. If that is true, gentlemen, why don't they come in here fairly and frankly with a bill that will permit the Governor to appoint from any school he wants to appoint from, excepting to require him not to appoint a majority from any one school of healing? Why, this Medical Society that has some 3,000 members and that has a large sinking fund and all kinds of power and influence,—they imagine somehow if they can ride this bill through the legislature that then they are in position to bring enough political pressure upon this Governor or some other Governor so that eventually that board will be entirely dominated and controlled by the Medical Society of Wisconsin, and when it is controlled and dominated by the State Medical Society of Wisconsin, there isn't a member of any other school of healing that will have a fair chance. Now, I say that advisedly. That very thing has happened; it has happened all over the country. By the way, I want to read you,—I just happened to come across this today, and I am intruding a little bit on Mr. Corrigan when I do it, because it was a publication printed by the Osteopathy Board, in which their president has gone into this subject carefully all over the country and he finds, for instance, this thing happened. "In Texas and Washington where they had control"—where one school of healing had control of this board—"there was discrimination in the grading of osteopathic physicians' papers, and it was only after expensive litigation in each state that the board was forced to give fair grades to papers which were shown in court to have been graded low, not because they deserved such but obviously because osteopathic applicants had written them. In fact, it was shown on the trial that the provisions of the law made principally to prevent an examiner on grading the papers from knowing the identity of the writers had been openly and evidently purposely violated."

And as I say, these different schools of healing are just as intolerant of one another as they can possibly be. The homeopath, for instance, I am told, when he vaccinates for smallpox believes in giving that medicine internally through the mouth; and the allopath believes in scratching the arm, and they have actually attempted in other states where they have had control of these boards to prevent that man from giving that identical dose of medicine which has the identical effect through the mouth, because that school of healing taught that the arm had to be scratched.

Now, I listened to some statements that I must take exception to. Mr. Crownhart has indicated that there were some 21 states that had a similar law to this. I have made a very careful investigation of that, and I find that there are 41 states in this union where no school of healing is in a majority, where it has the power to examine the other members. Now, there are a great many states, for instance, which have separate boards,—a separate board for the allopaths, and a separate board for the eclectics, and a separate board for the osteopaths, and the homeopaths, and of course they are included within that 41. But I say there are 41 states in this union where no school of healing has a right to sit in judgment in a majority on any other school of healing. And I will go further and I will say this and challenge contradiction: that there isn't one of those states that has ever had that system preventing a majority in one school that has ever turned back that page and given a majority to any one school. You are asked, gentlemen, to do something that has never been done in this country. And for what? Why, they say to make the appointments for the Governor easier. Well, the body that I represent has somewhere around 150 practicing physicians in this state; and the schools that are in existence—the homeopathic schools that are in existence and from which they now come are all Class A medical schools. They all require a person entering as a student to be a college graduate, and they require all the training that the ordinary allopathic school requires, and they require the internship in a hospital. Now, there are 150 of these men in the State of Wisconsin; and I dare say that any Governor can select from those one or two who are honest, conscientious, public-spirited men and willing to give their time and trouble to the job. If there aren't one or two honest men in 150 professional men, we are in a sad plight indeed.

Now, I dare say that it doesn't make any difference to the Governor. In fact, I know that the Governor has never given this any thought. And the only purpose in it, of course, is to induce somebody who might be a friend of this Governor or the oncoming Governor to change this law so that the State Medical Society of Wisconsin could once more get control of this Medical Board. I might say this: When the Pollard case that was discussed this afternoon—when that case came to the court for decision, if I am not mistaken (and if I am mistaken I will be corrected), that up until that time the Medical Society had almost continuously recommended appointments to this Board of Medical Examiners. Since that time they have not. Why, it was only a few years ago, gentlemen, that the Medical Society and the leaders in the Medical Society objected to the Governor going outside of

a narrow list that they submitted to select the members of this board. A few years ago they wanted him to select from 10 or 12 or 20 names. Now, they want him to have greater latitude. I wonder why that is. We cannot forget in these things that there are some selfish motives. The most charitable view you can take of this thing is that the members of this Society who are clearly in the majority think that they are honest motives and that they are unselfish motives. I imagine they think they are public spirited, but every once in a while something crops up that leads you to believe otherwise.

Now, I am going to quote just a moment from the Chairman of the Committee on Public Policy of the State Medical Society of Wisconsin when he was speaking to the Secretaries of the County Units. He said this: "So we do not feel we are under any obligation to the Society to solve wrongs; we are under obligation to inform the law-makers, and that is where the County Society and the individual members of the County Society come into play. Their duty lies in seeing that their representatives understand the laws that we are asking to have enacted, and to have them see the thing that we are asking for is in the interest of all the people and their constituents." And then he goes on to say: "We must not only have a selfish end in view. With reference to that I want to say as my first proposition that in the main these things which are for the public good are also for the good of the medical profession. Let me cite here one instance, namely that of laws governing who may treat the sick." And that indirectly is what we are getting at here, who may treat the sick. He says, "Is there any question in the mind of any one that the medical profession has benefited by the enactment of such laws? Still they were put on the statute books not by the medical profession particularly, but because it was a benefit to the medical profession and a benefit to mankind and a benefit to the health of the people of Wisconsin."

Now, they will tell you, of course, that they don't care whether there are two eclectics appointed, or two homeopaths appointed. I challenge that statement. That is the very purpose of having that legislation enacted, so that the allopaths may control that board. Oh, they will tell you that they are not trying to encourage any kind of litigation; that they are trying to be fair to all the schools of healing. Well, I just looked at one Journal last night of the State Medical Society, which I think demonstrates very clearly that they are trying to influence legislation. I find on page 470 of the Wisconsin Medical Journal published in August, 1930, that they had an attorney in Madison who is now holding a state office, and I suppose he is still their attorney; I find that their president holds a state office under the very dome of this capitol; and I find on looking over the expenditures that they have expended a couple of thousand dollars,—for what purpose we don't know—to a news service here in Madison. For what purpose we don't know, but it happens that the news service is very close to the political channels of this state.

Now, ladies and gentlemen, the homeopaths of this state are not strong enough to organize a large fund to have men constantly on the job; we can't afford to maintain an office here at Madison as the Medical Society does. All we can do is to come before this body and ask you to continue a thing that has given harmony through all these years in these different healing arts. We ask you to bear in mind that the homeopathic colleges are among the best in the country; and that while there are only a few now that several are under construction and organization, and that the profession is rapidly growing all over the world; that in the United States alone the increase in homeopathic figures last year was 60 per cent over the year before, and the decrease in allopathic was very nearly 50 per cent. And who can tell but what five years from today or fifty years from today, if we leave every branch of this healing art to go unbridled and pursue its studies, that it may develop that the allopaths were all wrong and it may be proven some years from now that the homeopaths were all right. It may develop that instead of having 200 homeopaths and 2 or 3,000 allopaths in 1950, we may have 3,000 homeopathics and 200 allopathics. Nobody can tell. These things undergo changes from day to day, from year to year, and from decade to decade. Whatever is to be said here will be said by other people. I don't want to take any more of your time. I merely want to appeal to you as reasonable men not to turn the control of this body over to any one group; and if you do, I am certain that the same troubles will ensue here that have ensued in other states. I thank you.

Mr. Henry A. Staab: Mr. Chairman and members of the Committee. Henry A. Staab, Milwaukee. I am registered during this session of the legislature as a representative of the chiropractors of Wisconsin. I am not here directed by this organization to appear against this bill, but because of my experience as chairman of the Public Welfare Committee of the Assembly in the sessions of 1925 and 1927, I am taking it upon myself to appear against this bill. I am doing it because of past experiences, as I have found them, sitting in the same places that you men are sitting—and Mrs. Charbonneau, pardon me—listening in on what appears to be a selfish motive on the part of one group in the matter of those licensed under the health acts of the state. In 1897 the health act of the state was passed, and our practicing physicians of that time, those who were practicing the healing arts, were licensed. Like all acts, that act could not be made retroactive, and all practicing physicians of that time came in under the wire. It was said that the osteopaths came before this legislature in 1915 and gained official recognition at that time. That was before my time. But in 1925 there came to us the

basic science act, which provided for certain requirements of those engaged in the healing arts. And at that time it was said by Mr. Crownhart that this was the highest pinnacle of efficiency that could be reached in the practice and licensing of the healing arts. I felt that the job was done at that time when the basic science act was passed. In 1927,—the reason I allude to those dates is because the medical profession or the allopaths have not been consistent. In 1927 there was introduced the quarantine bill which provided in essence that no one excepting those licensed under the medical act and clergymen, for the administration I believe of religious acts, shall enter the home of quarantine. And as chairman of that committee at that time, I took it upon myself to amend that bill to read that those who are licensed under the basic science act should be so included. This bill came from that group, and when that amendment was plastered on, an amendment that would treat them fairly,—all of those engaged in the healing arts, they didn't want the bill. The bill in spite of it was passed through the Assembly by an overwhelming vote, and was lost in the Senate by one vote.

Now, I told you that I am registered as a representative of the chiropractors of Wisconsin. Chiropractic asks for no favors. Chiropractic is prepared to meet its fate at the hands of a mixed group. We want to point out to you the grave danger of placing the Board of Examiners in the State of Wisconsin in the hands of a single group. When the quarantine bill was discussed on the floor, Dr. McDowell (then a member of the Assembly) made this statement: That during the past 30 years human life had been prolonged by 10 years because of the discoveries in medical science. I didn't intend to discuss that bill on the floor of the legislature, but I did say this: That the good doctor forgets that in 30 years there has come into the human family other developments, as has been truly said before,—other developments in the healing arts, that can claim all that honor,—yes, including the Christian Science Church, I say that.

I believe, members of this Committee, that your great concern should be for those of the state. It was said that there are 150 homeopaths in the State. There are 550 chiropractors in the state who have patrons. We are not asking for representation on the Board, but we have cast our lot with a mixed board at the present time, and are much in favor of permitting it to remain as it is and not placing the board of examiners under the domination of any single group. I believe the people of Wisconsin should have that right. And in your consideration of this bill, I hope that the people's rights in this matter will be considered first of all. I am not going to tell you how many chiropractors each one of you have in your district; I am not going to minimize it,—I am not going to minimize any group. I am asking you only to be considerate of those men who have been licensed by the medical act of 1897 and who are practicing today with remarkable results. As chairman of this committee in 1925 my attention was called particularly to the case of a young man who had been vaccinated and whose arm and shoulder and neck and breast and back was covered with a scab 1½ inches thick, who was sent back from Johns-Hopkins in Baltimore to the State of Wisconsin I think to die; and my attention was first called to chiropractic at that time. I haven't had the need of a physician twice in my whole life and I am 55, but I was considerate of what they were doing, and I was much surprised to know that even that condition, that case, was handled effectively and successfully, with the young man before the committee exposing his body to show them what had been done by a chiropractor, if you please. And I plead for these various groups with this committee. But stay in the middle of the road and give the people the right to choose whom of the medical profession or those engaged in the healing arts they want. Thank you.

Chairman: Any questions? Anyone else opposed to the bill?

Mr. Stanley Slagg (Assemblyman, Edgerton, Rock County): I want to say to this committee that I have had experience with all branches of the healing profession, I presume. I have seen the treatment of the allopaths, I have gone to allopathic doctors; and I have gone to homeopathic doctors; and I have gone to osteopaths; and I have had experience with chiropractors. And I want to say to this committee that I think that all of these branches of the healing art have a very distinct place in our social condition at the present time, and I see no reason for the passage of a bill of this kind. It seems to me that any Society which seeks to put this kind of legislation across upon the people of the state of Wisconsin have lost some of their hold on their position in society. And it seems to me that any institution in that Society, or any healing art which attempts to say that they should have the controlling force upon any board is weakening their own position, and I wouldn't think that any Society would be backing a proposition of this kind. Now, down in my district we have osteopaths, and we have chiropractors and homeopaths and we have allopaths, and they are all very successful. They are all contributing their distinct bit to the healing profession. Perhaps most of us aren't familiar with what the homeopath represents, but my conception of a homeopath has been more or less that country type of physician who has had such a distinct place in American history. I know from my own experience in my early years that our family physician was a homeopath and one from whom I received a considerable amount of treatment; and I want to say that I have always felt a very distinct obligation to that branch of the healing profession. I have always felt that the medicines which the homeopaths deal out are less stringent and are much easier to take than the allopathic medicines are, and I think that so far as

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PRESS SERVICE OF STATE MEDICAL SOCIETY

No serum does so much for public health as printer's ink

GOITER

Madison, Wis., March 25.—Because goiter is such a common disease in Wisconsin, the Educational Committee of the State Medical Society in a bulletin issued this week advises continued study of the problem by medical authorities and the utilization of the latest scientific medical treatment.

"Goiter, or big neck, as you may have heard it called," says the Medical Bulletin, "is an enlargement of the thyroid gland. This gland is situated in the front of the neck and is shaped something like a dumb-bell, a small sac or lobe being located on each side of the windpipe, connected with one another across the front by a band called the 'isthmus.'

"The thyroid gland has numerous cavities filled with a thick fluid known as the 'colloid' which is absorbed slowly into the blood stream. There it has the power of markedly affecting the health of the individual. One of its chief functions is that of regulating the rate at which the body uses up its fuel supply.

"So long as the thyroid gland acts normally, you do not know you have one. Trouble arises immediately, however, if the secretions of this gland are over or under-abundant. If too abundant, a characteristic train of symptoms develops such as palpitation of the heart, muscular tremors, nervousness and digestive disorders. Often an enlargement of the gland occurs and in some cases the eyeballs become prominent. When the latter appears the disease is known as 'exophthalmic goiter.'

"If the thyroid gland fails to develop normally too little secretion is formed with the result that there is a general slowing up of the bodily functions, both mental and physical. When this condition occurs in young children they become what are known as 'cretins.' They are dwarfed, often bodily deformed and frequently idiots. In some sections of the world—notably the Alps and Himalaya Mountains—cretins are very numerous.

"The thyroid gland has been found to contain practically all of the iodine that there is in the body. When there is not enough iodine taken into the body to satisfy its needs or if it is used up faster than it is supplied, simple goiter—or mere enlargement of the gland—occurs.

"To prevent goiter in a number of instances local authorities have given people iodine internally with beneficial results. The amount of iodine needed to avoid simple goiter is so small that it cannot possibly harm any one."

THE MICROSCOPE

Madison, Wis., April 1.—A little piece of machinery destroys more fear than all the encouraging words of men. Tests are made with this machinery to determine whether tumors are of a cancerous nature. Many people who have great fear of cancer find, upon consideration, that a simple microscopic test will give a correct answer.

"A half a dozen brass polished microscopes in the laboratory will correct fear of cancer," declares the Educational Committee of the State Medical Society in a bulletin issued today. "The court of last resort is the microscope, by the aid of which the structure of the tumor can be ascertained, for, while both benign and malignant tumors are the products of cellular overgrowth, the cells of a benign tumor are normal and present an orderly grouping, while the cells of a malignant tumor are abnormal and grow in a lawless and disorderly fashion.

"To many persons the words 'tumor and cancer' signify the same thing—an assumption far from correct. 'Tumor' is derived from the Latin and means simply a swelling. 'Cancer' comes from the Greek word carsinos, meaning a crab, and signifies a malignant growth.

"Since cancerous growths form masses, all cancers are in a general sense tumors, but all tumors are by no means cancers, not even when they result from excessive tissue growth, for many such tumors possess no cancerous or malignant properties and are not in themselves dangerous to life.

"Whenever a mass, a tumor or a growth is discovered, therefore, it becomes of the greatest importance to the patient to discover its nature for, until the cause of cancer and its method of operation have been discovered, the best chance for the control of cancer lies in its early diagnosis and the prompt removal of the growth.

"The discovery of a tumor mass hence leads at once to the questions, 'What sort of a tumor is this? Is it cancer?' For if it is a cancer, it should be removed at once and entirely, while if it is a simple and non-malignant tumor, its removal to some extent becomes a matter of choice.

"While tumor masses are discoverable by ordinary methods of examination, their nature, of what they are composed, and their exact future relation to health and life are not so discoverable, especially when they are small and inconspicuous, the very time when the treatment for cancers is more efficacious.

"Every tumor, regardless of its size or appearance, demands investigation, for a benign and relatively harmless tumor may reach enormous size and a cancer may have a small and insignificant beginning. Moreover, a tumor that commences as a simple and benign growth at some later date may become cancerous, so that an exact determination of the nature of a tumor becomes imperative as soon as it is discovered."

NERVOUS CHILDREN

Madison, Wis., April 8.—Many symptoms of nervousness among children can be traced directly to some error in feeding. Sometimes children are dosed too much with "patent medicines," or made irritable by an infinite number of attempts to kill the child with kindness.

The Educational Committee of the State Medical Society in a bulletin issued today declares that too much attention should not be given to alleged nervousness in the child, but should be helped by the gentle patience of the parent.

"Those of us whose business it is to listen to parents' tales of woe about their children have come to expect nearly all children to be accused sooner or later of nervousness," declares the Bulletin. "Now, if by nervousness we mean activity, we are willing to grant that all normal children are nervous.

"It is when normal activity becomes intolerably annoying to grownups that they are likely to exclaim in helpless anger that the child is nervous—thus making matters far worse.

"Having protested thus early against branding innocent children as nervous, we must hasten to de-

(Continued on page 402)

THE JOURNAL BOOK SHELF

A Text-Book of Gynecology. By Arthur Hale Curtis, M. D., professor and head of the department of obstetrics and gynecology, Northwestern University Medical School; chief of the Gynecological Service, Passavant Memorial Hospital, Chicago. 222 original illustrations. W. B. Saunders Company, Philadelphia and London, 1930.

Abdomino-Pelvic Diagnosis in Women. By Arthur John Walscheid, M. D., Director of Obstetrical and Gynecological Department of Broad Street Hospital; Director of Obstetrical and Gynecological Department of Pan-American Medical Center and Clinics, New York City; Consultant in Gynecology and Obstetrics to Margaret Hague Maternity Hospital, Jersey City, N. J.; Consulting Gynecologist to Bergen County Hospital, Ridgewood, N. J.; Consulting Gynecologist to the F. Reuter Home, North Bergen, N. J.

Operative Gynecology. By Harry Sturgeon Crossen, M. D., F. A. C. P., professor of clinical gynecology, Washington University School of Medicine; gynecologist in chief to the Barnes Hospital and the Washington University Dispensary. And Robert James Crossen, M. D., instructor in clinical gynecology and obstetrics, Washington University School of Medicine. 4th edition. 1246 illustrations and 2 color plates. Price $15.00. C. V. Mosby Co., St. Louis, Mo.

The Treatment of Fractures. By Lorenz Böhler, M. D., Chief Surgeon and Director of the Vienna Accident Hospital. Authorized English translation by M. E. Steinberg, M. S., M. D., of Portland, Oregon. Formerly senior officer on the surgical service of the U. S. Public Health Service Hospital, and consultant surgeon to the U. S. Veterans' Bureau at Portland, Oregon. With 234 illustrations. Vienna, Wilhelm Maudrich, 1929.

Grow Thin on Good Food. By Luella E. Axtell, M. D. 12Mo, Cloth. 344 pages, illustrated, indexed. Price $2.00. Funk & Wagnalls Company, New York.

How it Happened. By Adalbert G. Bettman, M. D. Price $1.00 net. F. A. Davis Co., Philadelphia.

Allergic Diseases. Their diagnosis and treatment. By Ray M. Balyeat, M. D., F. A. C. P. Director of the Balyeat Hay-Fever and Asthma Clinic, Oklahoma City. Illustrated with 87 engravings, including 4 in colors. Third edition, revised and enlarged. Price $5.00 net. F. A. Davis Company, Philadelphia.

Intestinal Toxemia. By Anthony Bassler, M. D., F. A. C. P., consulting gastroenterologist, St. Vincent's, Peoples' and Jewish Memorial Hospitals, New York City; St. John's Hospital, Yonkers; Christ Hospital, Jersey City. Illustrated with 16 text cuts. Price $6.00. F. A. Davis Company, Philadelphia, 1930.

Normal Facts in Diagnosis. By M. Coleman Harris, M. D., lecturer on physical diagnosis. New York Homeopathic Medical College and Flower Hospital and Benjamin Finesilver, M. D., lecturer on diseases of the nervous system, New York Homeopathic College and Flower Hospital. Illustrated with forty-two engravings, some in colors. Price $2.50 net. F. A. Davis Company, Philadelphia.

Text-Book of Medicine. Edited by Russell L. Cecil, M. D., assistant professor of clinical medicine in Cornell University; assistant visiting physician in Bellevue hospital, New York City. Associate editor for diseases of the Nervous System, Foster Kennedy, M. D., professor of neurology in Cornell University. Second edition, revised and entirely reset. 1592 pages. W. B. Saunders Company, 1930. Cloth $9.00.

Doctor and Patient. By Francis W. Peabody. M. D., Professor of Medicine, Harvard Medical School, director of Thorndike Memorial Laboratory, visiting physician and chief of the fourth medical service, Boston City Hospital 1921 to 1927. Price $1.50. The Macmillan Company, New York.

Microbiology and Elementary Pathology. By Charles G. Sinclair, B. S. M. D., Major, Medical Corps, U. S. Army. Instructor in bacteriology, Army Medical School. With 102 illustrations, some in colors. Price $2.50 net. F. A. Davis Company, Philadelphia, 1931.

Doctors and Specialists. A medical revue with a prologue and a good many scenes by Morris Fishbein, M. D., editor of Journal of the American Medical Association and Hygeia. Price $1.00. The Bobbs-Merrill Company, Indianapolis.

Physical Diagnosis. By Warren P. Elmer, B. S., M. D., associate professor of clinical medicine, Washington University, and W. D. Rose, M. D., late associate professor of medicine in the University of Arkansas. With 337 illustrations. Price $10.00. C. V. Mosby Company, St. Louis, 1930.

A Manual of Normal Physical Signs. By Wyndham B. Blanton, B. A., M. A., M. D., assistant professor in medicine, Medical College of Virginia. 2nd edition. Price $3.00. C. V. Mosby Co., St. Louis, 1930.

Treatment of Epilepsy. By Fritz B. Talbot, M. D., clinical professor of pediatrics, Harvard University Medical School; chief of Children's Medical Department, Massachusetts General Hospital. Price $4.00. Macmillan Company, 60 Fifth Ave., New York, 1930.

A Compend on Bacteriology. By Robert L. Pitfield, M. D., attending physician, Germantown Hospital, Philadelphia. And Howard W. Schaffer, M. D., pathologist to the Memorial Hospital, Philadelphia; fifth edition, 82 illustrations and 4 plates. Price $2.00 net. P. Blakiston's Son & Co. Inc., 1012 Walnut St., Philadelphia.

Chronic Arthritis and Rheumatoid Affections. By Bernard L. Wyatt, M. D., F. A. C. P., director, The Wyatt Clinic; formerly associate director, The Rockefeller Commission to France. Price $2.50. William Wood & Company, 156 Fifth Ave., New York.

Diseases of the Digestive System, Volumes I and II. By L. Winfield Kohn, M. D., F. A. C. P. Formerly assistant in the gastro-intestinal clinic, Johns Hopkins Hospital; chief of the clinic of gastro-enterology, Medico-Chirurgical College, Philadelphia; present chief of the gastro-intestinal clinic, Lebanon Hospi-

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tal, New York City. Illustrated with 542 engravings, including 7 full page colored plates. Price of two volumes $12.00 net. F. A. Davis Company, Philadelphia, 1930.

Clinical Obstetrics. By Paul T. Harper, Ph. B., M. C., Sc. D., F. A. C. S. Fellow of the American Association of Obstetricians, Gynecologists, and Abdominal Surgeons, and of the New York Obstetrical Society. Clinical Professor of Obstetrics, Albany Medical College. Regional Consultant in Obstetrics, New York State Department of Health. Illustrated with 84 plates of engravings (250 figures) with legends and charts. Philadelphia F. A. Davis Company, Publishers, 1930.

Clinical Laboratory Methods. By Russel L. Haden, M. D., Professor of Experimental Medicine, University of Kansas, School of Medicine. Third edition. Price $5.00. C. V. Mosby Company, St. Louis, 1929.

Practical Psychology and Psychiatry. By C. B. Burr, M. D., Sixth edition. Price $2.75 net. F. A. Davis Co., Philadelphia, Pa.

Insomnia. By Joseph Collines, M. D. Price $1.50. D. Appleton and Company, New York.

Infant Feeding in General Practice. By J. V. C. Braithwaite, M. D., M. R. C. P. (Lond.), physician and physician in charge of Children Out-Patients, Leicester Royal Infirmary and Children's Hospital; late assistant Queen's Hospital for Children, London. Price $1.75 net. William Wood & Co., 156 Fifth Ave., New York, N. Y.

A Manual of Diseases of the Nose, Throat and Ear. By E. B. Gleason, M. D., professor of otology, Graduate School of the University of Pennsylvania. Sixth edition, thoroughly revised. 12 mo. of 617 pages with 262 illustrations. Cloth, $4.50 net. W. B. Saunders Company, Philadelphia, and London.

Nursing Technic. By Mary C. Wheeler, R. N., former superintendent of Illinois Training School for Nurses; and Amalia Metzker, R. N., instructor, St. Luke's Hospital School of Nursing, Racine. Third edition completely revised and reset. J. B. Lippincott Co., Philadelphia.

Clinical Allergy, Particularly Asthma and Hay Fever. By Francis M. Rackemann, M. D., physician to the Massachusetts General Hospital; Instructor in medicine, Harvard Medical School. Price $10.50. The Macmillan Co., 60 Fifth Ave., New York City.

Ante-Natal Care. By W. F. T. Haultain, O. B. E., M. C., M. B., senior assistant obstetric physician and late special assistant to ante-natal departments, Edinburgh Royal Maternity and Simpson Memorial Hospital. And E. Chalmers Fahmy, M. B. (Edin.), assistant obstetric physician and special assistant to ante-natal department, Edinburgh Royal Maternity and Simpson Memorial Hospital. Second edition. Price $2.25 net. William Wood & Co., 156 Fifth Ave., New York, N. Y.

Modern Methods of Treatment. By Logan Clendening, M. D., professor of clinical medicine, lecturer on therapeutics, medical department of the University of Kansas. Fourth Edition. Price $10.00. C. V. Mosby Company, St. Louis, Mo.

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Modern Surgery. By J. Chalmers DaCosta, M. D., LL.D., F. A. C. S., Samuel D. Gross, professor of surgery, Jefferson Medical College, surgeon to Jefferson Medical College Hospital, consulting surgeon to the Philadelphia General Hospital, St. Joseph's Hospital and Misericordia Hospital, Philadelphia. Assisted by Benjamin Lipshutz, M. D., F. A. C. S. Surgeon to the Mt. Sinai Hospital; associate in neuro-anatomy, Jefferson Medical College. Tenth Edition, revised and reset. 1404 pages with 1050 illustrations, some in colors. Philadelphia and London. W. B. Saunders Company, 1931. Cloth, $10.00.

BOOKS RECEIVED FOR REVIEW

The Criminal, The Judge, and The Public. By Franz Alexander, M. D., visiting professor of psychoanalysis at the University of Chicago, and Hugo Staub, attorney-at-law, Berlin. Translated from the German by Gregory Zilboorg, M. D., Bloomingdale Hospital, White Plains, N. Y. Price $2.50. The Macmillan Company, 60 Fifth Avenue, New York.

The Letters of Dr. Betterman. By Charles E. Blanchard, M. D. Author, Betterman II on the Business of Medicine, Our Altruistic Individualism, A Text-Book of Ambulant Proctology. Price $1.00. Medical Success Press, Youngstown, Ohio.

Crippled Children. By Earl D. McBride, B. S., M. D., F. A. C. S. Instructor in orthopedic surgery, University of Oklahoma, School of Medicine; attending orthopedic surgeon to St. Anthony Hospital; associate orthopedic surgeon to Oklahoma City General and Wesley Hospitals. Price $3.50. C. V. Mosby Company, 3523 Pine Blvd., St. Louis, Mo.

The Diagnosis and Treatment of Brain Tumors. By Ernest Sachs, A. B., M. D. Professor of clinical neurological surgery, Washington University School of Medicine, St. Louis. 224 illustrations, including ten in colors. Price $10.00. C. V. Mosby Company, St. Louis, 1931.

Discovering Ourselves. A view of the human mind and how it works. By Edward A. Strecker, A. M., M. D., and Kenneth E. Appel, Ph.D., M. D. Price $3.00. The Macmillan Company, 60 Fifth Avenue, New York.

Report of the Department of Health of the City of Chicago for the years 1926 to 1930 inclusive. By Arnold H. Kegel M. D., D. Sc., F. A. C. S. Commissioner of Chicago, Chicago, 1931.

The American Journal of Cancer. A continuation of the Journal of Cancer Research. Editor, Francis Carter Wood, The Institute of Cancer Research of Columbia University.

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BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Secretary, Mr. J. G. Crownhart, 119 E. Washington Ave., Madison, Wisconsin. These new books will be loaned for an inspection period only.

Symptoms of Visceral Diseases. A study of the vegetative nervous system in its relationship to clinical medicine. By Francis Marion Pottenger, A. M., M. D., L.L. D., F. A. C. P., Medical Director, Pottenger Sanatorium for Diseases of the Lungs and Throat, Monrovia, California; Author of "Clinical Tuberculosis," "Tuberculin in Diagnosis and Treatment," "Muscle Spasm and Degeneration." Fourth edition, with 87 text illustrations and ten color plates. Price $7.50. C. V. Mosby Co., St. Louis.

This book requires very careful study as it is an exceedingly thorough going effort to put together in one volume the different phases of visceral neurology including its anatomical, physio-logical, pharmacological and clinical aspects. While many clinicians might find room for argument in its clinical application such a painstaking and scholarly presentation of the basis of visceral symptoms will well repay the earnest student of general medicine. E. L. B.

Physical Examination and Diagnostic Anatomy. By Charles B. Slade, M. D., formerly chief of clinic in general medicine, University and Bellevue Hospital Medical School, New York. Fourth edition, thoroughly revised. 12 mo. of 196 pages with 43 illustrations. Cloth $2.00 net. W. B. Saunders Co., Philadelphia and London, 1929.

This is an excellent text book for students. This, the 4th edition, is practically unchanged save for the addition of an appendix devoted to the physical signs of tuberculosis. This addition is especially valuable for a beginner in that it emphasizes a very few salient findings with which even a beginner can diagnose early tuberculosis. One could only wish that the author would add just such an appendix to cover the main types of heart disease,—etiologically considered. E. L. B.

Surgical Pathology of the Diseases of the Bones. By Arthur E. Hertzler, M. D., surgeon to the Agnes Hertzler Hospital, Halstead, Kansas. Published by the author.

There has been a great need for a book that treats in a comprehensible manner the pathology of the diseases of bones. It is only in well-manned laboratories that adequate study of bone lesions is possible, careful study of bone lesions is absent in most laboratories, so that every teacher of pathology or surgery has realized the advisability of collecting all specimens from operating rooms and autopsy table, with the case histories, roentgenograms and clinical laboratory notes that a complete knowledge of bone pathology and its relation to general and chemical pathology, might be ascertained.

Hertzler is one of America's master surgeons whose knowledge of general pathology and a scientific study of bone lesions over 30 years has especially qualified him to speak authoritatively on this subject. He has privately published in a monogram of 272 pages, a thorough description of bone lesions, illustrated by cases, giving the history, roentgenograms, macrophotographs and microphotographs and end results, with a number of illustrations by Tom Jones.

A lengthy bibliography is omitted as "every medical man with any pretense at learning has the Cumulative Index at his elbow."

His object in writing the book is to serve practical surgery. This he has admirably accomplished.

This book can be read with profit by every surgeon who treats bone lesions. W. J. C.

Piersol's Human Anatomy. Including structure and development and practical considerations. 9th edition revised, under the supervision of G. Carl Huber, M. D., Sc. D., professor of anatomy; director of anatomic laboratories and dean of the graduate school, University of Michigan. 1734 illustrations. J. B. Lippincott Co., Philadelphia.

Dr. G. Carl Huber, professor of anatomy, University of Michigan, has supervised the 9th edition, revised, of Piersol's Human Anatomy. The task of the editor has been excellently accomplished. The three objectives of this text book of anatomy are the following:

1. The presentation of the essential facts of human anatomy by a descriptive text.
2. The correlation of anatomical details with clinical practice.
3. Illustrations of actual dissections.

This text book contains 2100 pages. This apparently overwhelming number of pages is due to the comprehensive objectives. The human body is considered from the standpoint of development, histology, gross anatomy and practical applications. It is easy of reference. The plates are clear and of good size. The volume is excellently indexed and attractively printed. E. J. C.

Traumatotherapy. By John J. Moorhead, B. Sc., M. D., professor of surgery and director, department traumatic surgery, New York Post-Graduate Medical School and Hospital; surgical director, Reconstruction Hospital Unit; colonel medical officers reserve corps, U. S. Army. 574 pages with 625 illustrations. Price $7.00. W. B. Saunders Co., Philadelphia and London, 1931.

While undoubtedly ideal as a review for the writer's former interns (Preface), this volume lacks the detail necessary in a surgery textbook, and is too inclusive for a handbook. A chapter on antiseptics is profusely illustrated with cuts of splints. Other

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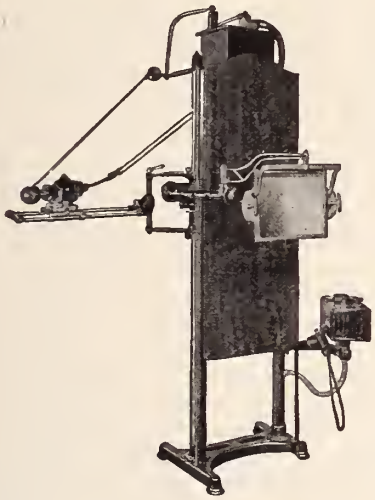

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plates are scattered through the book with only occasional reference to them in the text. Surgical subjects are handled largely in outline form and many tested methods are presented. Some of the chapters are excellent, as one might expect of a *one man book* with an author of such wide experience. As a suggestive outline of the treatment of miscellaneous injuries, the book should be useful to many general surgeons. W. P. B.

Recent Advances in the Study of Rheumatism. By Frederic John Poynton, M. D., F. R. C. P. (London). Physician, University College Hospital; senior physician, Hospital for Sick Children, Great Ormond St., and Bernard Schlesinger, M. D., M. R. C. P. (London). Physician to Children's Department, Royal Northern Hospital. 25 illustrations. Price $3.50 net. P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia.

This monograph undertakes the formidable task of attempting some correlation in this chaotic field. Their first attack is made on nomenclature, but they admit that any classification will be unsatisfactory until it can be made upon the basis of proved etiology. They resort to a simple division, into acute and chronic forms.

Acute rheumatism is analyzed in considerable detail with reference to predisposing causes—pathology, bacteriology and therapy. The old problem of tonsils and rheumatism is reviewed. The emphasis on treatment is praiseworthy and comprises a comprehensive program from the prerheumatic stage to convalescent supervision. The provisions for convalescent care are particularly of value.

Their discussion of chronic rheumatism is satisfactory, but contains nothing of a revoluntionary character.

In brief this volume presents a very compact and authentic review of a very difficult problem. The literary style makes reading somewhat difficult.

J. H.

Cancer. Its origin, its development and its self-perpetuation. The therapy of operable and inoperable cancer in the light of a systemic conception of malignancy. A research by Willy Meyer, M. D., consulting surgeon to the Lenox Hill and Postgraduate Hospitals, New York Infirmary for Women and Children, etc., emeritus professor of surgery, N. Y. Postgraduate Medical School. Price $7.50. Paul B. Hoeber, Inc., New York, N. Y.

The author states in the preface that "the term 'cancer' is used in this book to include every kind or type of malignant growth",—surely a strange definition. The book is composed of two parts: Part I, in which there are 29 chapters, is devoted to the consideration of the origin, development and self-perpetuation of "cancer" and the author develops the thesis that "cancer" is a systemic disease. In Chapter I, the role of parasites, and in Chapter II, the role of human intestinal parasites in an etiological sense is considered. It may be said that the author's treatment of the subject matter in these two chapters is quite instructive and from a pathological viewpoint, thoroughly conventional. He unqualifiedly rejects the germ or parasitic theory in a specific sense, (thereby taking issue with Coley, Sir John Bland-Sutton and Heidenhain), but shows, mostly by free quotations from the literature that cancer in the human subject may be and indeed frequently is produced by means of parasites acting, not in a specific sense but as a chronic irritant only. The author proves very convincingly that cancer is produced by chronic and long-continued irritation, (no longer news).

These two chapters are followed by 129 references to literature. In fact, numerous references are quoted throughout the book and the author seems most fastidious in this matter. Up to this point, the author has his feet firmly on the ground. This statement cannot be made for the chapters that follow, wherein he gives his imagination free rein. The result is a book difficult to read, the difficulty being accentuated by the interpolation of innumerable quotations from widely disseminated courses, the quotations frequently taking up more space than the author's remarks. When one considers how easy it is for scientific investigators to follow false scents leading nowhere, one is amazed at the way the author builds up a complicated and extensive structure composed of a mass of theories and hypotheses, a house of cards, intended to explain cancer. The author postulates as necessary conditions for the development of malignant growths, a succession of theories, (often poorly substantiated), in which he assumes the presence of low serum resistance, imbalance of nerves, endocrine dysfunction, an abnormal psyche (for which modern living conditions are held responsible), but emphasizes an alleged state of alkalosis as a *sine qua non, par excellence*, a point said to have been disproved and discredited.

The entire structure is strongly reminiscent of the house that Jack built or of a pyramid, base up. The occasional, successfully employed treatment of Coley's fluid in sarcoma is attributed to the induction of a state of alkalosis. The recession of new growths during and following infectious fevers is likewise attributed to the supposed state of acidosis induced thereby, differing with Tuffier who credits the favorable effect to the elevation of temperature. The favorable effects noted sometimes following great hemorrhages are explained by the dilution of the "necrones," cell waste products which act as stimulants to cell division. I quote from page 341, "The obvious remedy for cancer it seems to us, is acidosis, clinical or relative, in whatsoever way originating, or by whatsoever means produced. One of these ways is fever, arising from infectious diseases. Rhodenberg, who from the literature collected more than 300 cases of sporadic recession of malignant tumors, mentions as infectious diseases in the course of which these tumors were observed to disappear: erysipelas, smallpox, pneumonia,

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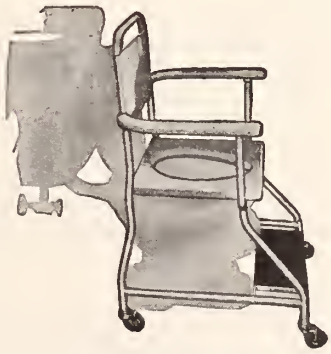

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malaria and acute tuberculosis. Coley names scarlet fever, typhoid, cholera, etc., DePage rabies." (References are given). One is intrigued to speculate as to the preferable mode of death, since acute tuberculosis is virtually always fatal and rabies is always so without exception. The author leaves one in doubt as to whether in the reported cases the patients recovered from both tumor and infection, or whether the infection cured the patient of the tumor, only to die of the infection.

In part II, treatment is considered. Operation is frankly advocated in "operable" cases. In inoperable cases, "rational" treatment is advised based on his extensive theories. "Cancer prophylaxis" is urged by means of blood testing of patients or prospective patients, correcting the supposedly abnormal conditions (alkalosis) by appropriate treatment.

One may well question a legitimate *raison d'etre* for this book. E. G. F.

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WISCONSIN INDIAN MEDICINE

That the Wisconsin Indians, like all other primitive people, vested their medical men with supernatural power is seen in many instances. Perhaps the instance of a Chippewa bear hunt, which is narrated in the Wisconsin Historical Collection (1), is more humorous to us than its near-tragedy to the actors would warrant: "The chief Medicine Man sits in the middle of the lodge, with some broadcloth and calico spread before him, together with a stuffed cub bear-skin, while his pipe or calumet, already filled, is placed before him on two crotched sticks. He then addresses the bear in this wise: 'O, my brother! we are very hungry; we are on the point of starving, and I wish you to have pity on us, and tomorrow when the young men go out to hunt you, I want you to show yourself. I know very well that you are concealed somewhere close by my camp here. I give you my pipe to smoke out of, and I wish you would have pity on us, and give us your body that we may eat and not starve.' Having thus spoken, he takes the medicine-drum and beats on it, accompanying it with some songs that he recites from two small boards on which they are written in hieroglyphics."

In another record (2) we find that "When a person is sick, they send for a doctor, who gets his pay in advance." This may sound enticing, but a further note detracts from the propitiousness, for if the cure is not effected the doctor is expected to give back his pay. Ordinarily, when we think of Indian Medicine Men we visualize painted Jugglers, Dancers, or Conjurers, and while this type of Medicine Man was probably predominant, yet other means were practised. Herb poultices were used, and the common remedy for open wounds seems to have been of sucking them clean. In the use of this latter method the Medicine Man would seem to need his supposed supernatural power, for "It is also the business of the Doctor to suck any old sore that he undertakes to cure, no matter how filthy, or disgusting, even venereal disorders and sore eyes;" (3). As in other primitive tribes, gynecology and obstetrics were unknown to the medical practicers, in fact, were 'taboo'. This fact may be counted as inculcated in their religion, and medicine itself played a large part in their religion; the Winnebagoes are known to have had a secret society by the translated name of "Medicine" (4), and the Grand Medicine-Bag of the Sacs reminds one very much of the West Indian or African charm bags; "The Me-shaum is a parcel or bundle in which are recorded by knots in strings, stones, etc., and also by hieroglyphical figures the names and wars of their gods in ancient times; and their religious belief also on revelation which they suppose was at first delivered to their ancestors by We-sah-kah, their tutelary god. * * * The Me-shaum is held in high veneration; none are permitted to open or inspect it, except the one having particular charge of it." (5)

That the Medicine Men of the Indian tribes were not shunned by the early white settlers is ascertained by record, but it is rather deprecating that these same records must record that while the Indian was glad to serve the white patient his pay was not so certain as when he doctored his own people. On the other hand, the attitude of the Indian to the coming of the white doctor is known to have been friendly, indeed, one of the utmost veneration. L.M.

[1] Wisconsin Historical Collection, I, p. 125.
[2] Wisconsin Historical Collection, II, p. 182.
[3] Ibid., II, p. 183.
[4] Ibid., XII, p. 423.
[5] Ibid., XV, p. 129.

PRESS SERVICE

(Continued from page 393)

scribe the child who really is nervous, the child who is to be the object of our discussion. The general condition may be defined in two words: abnormal irritability, that is, abnormal response to ordinary stimuli. There are all degrees of it, and it varies with the age of the child. Details will therefore be given for different ages. Some,—very few,—are born nervous. Others,—in later life,—achieve nervousness. Others,—the majority,—have nervousness thrust upon them.

"Are there such creatures as nervous infants? There are. But, thanks to the Divinity that shapes our beginnings, such infants are decidedly exceptional. It must be said that, whether they be Jew or Gentile, whether they be bond or free, the great majority of tiny babies are much like puppies or kittens: quiet when well fed and comfortable; fussy when hungry or in pain.

"Whatever symptoms of nervousness there are can usually be traced by the physician to some error in feeding, to too much dosing with patent cathartics or worm-medicine, or to any one of an infinite number of attempts to kill the baby with kindness. The

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed care Wisconsin Medical Journal.

WANTED—To form partnership with established physician doing some general surgery. Milwaukee preferred. Have an attractive proposition especially if interested in industrial work or small clinic. Will personally interview anyone who may be interested. Write No. 825 in care of the Journal. MAM

FOR SALE—McCaskey desk in very good condition. Originally $350. For further information address No. 832 in care of The Journal. AMJ

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FOR SALE—I Victor Universal 10″ x-ray machine. 1 No. 7 Combination table. 1 Victor Buckey, new type x-ray tubes and all accessories. All priced for quick sale. Telephone, Marquette 0374. Address Dr. M. W. Sherwood, 402 Strauss Bldg., Milwaukee, Wis. M.

FOR SALE—Victor 5″ Stabilized Unit, 220 V. D. C. with converter, standard fluoroscopic tilt table, two Coolidge tubes, Bucky Diaphragm and accessories. Will sell at a very low figure due to death of doctor. For further information consult Mrs. E. J. Purtell, 2637 North Summit Avenue, Milwaukee, Wis. AM

EXCELLENT LOCATION in northeastern part of state, twenty miles by concrete to hospital. Widow desires to dispose of location including office equipment, office and residence. Will sacrifice to make quick sale. Address No. 821 in care of The Journal. JFM

A FINE CHANCE to step into an old established practice. Home and office for sale if wanted. The only doctor in a thriving town of 800 and good farm surroundings. Address No. 835 in care of The Journal. MJJ

POSITION WANTED.—Experienced bookkeeper wishes permanent position in physician's office near Milwaukee. Four years experience in office work for physicians, including routine laboratory and x-ray work on Victor machine. Excellent references. Salary open. Address No. 836 in care of The Journal. M

EXCELLENT OPENING—Physician desires to leave general practice for clinic but desires to locate colleague before leaving. Location in southeastern Wisconsin in town of 800 population. Hospital available nearby. Address No. 837 in care of The Journal. MJJ

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FOR SALE—Physician's office and residence in West Bend, Wisconsin, city of 6,000 population. Several churches and schools, public and parochial. A city whose slogan is "the city of diversified industries," and is rated as one of the leading cit'es in Wisconsin for industry and progress. For further information, address No. 831 in care of the Journal. AMJ

LOCUM TENENS WANTED by capable physician for June and July. References furnished. Licensed in Wisconsin. Address No. 829 in care of The Journal. MAM

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average infant, properly fed, well supplied with fresh air, not too much interfered with, will usually be found asleep or blissfully staring into space, and the relatives will boast that they 'don't know there's a baby in the house.'"

* * *

MUMPS

Madison, Wis., April 15.—Reports from several cities in Wisconsin indicate that mumps is unusually prevalent at present. Spring is the season in which mumps thrives and in those communities in which it has obtained a foothold no great decline can be expected before summer weather, according to the bulletin issued by the State Medical Society today. It is pointed out that the disease is especially prevalent in southern Wisconsin and in some districts has spread rapidly.

The symptoms of mumps are commonly known to most people. It is an infection of the parotid gland and characterized by a boggy swelling without redness just in front of and below the ear. The swelling is much more extensive in some individuals than in others. One side of the face only may be involved but usually a similar swelling appears under the opposite ear within two or three days' time. Usually some fever, aching, headache and occasionally vomiting and earache precede or accompany the malady.

"Many parents consider that mumps means only a short period of inconvenience to the child," declares the State Medical Society's Bulletin issued today. "Fortunately, in the majority of cases, this will prove true but there are some, however, who develop complications and experience serious illness. The chief of these complications is the invasion of other glands in other parts of the body in both the male and female sex and this occasionally results in permanent damage. The person suffering from mumps, therefore, even if lightly affected should have adequate treatment. Rest in bed for a number of days, especially in adolescents and young adults, greatly lessens the chance of these complications. The appearance of any kind of unusual symptom urgently demands medical attention.

"The spread of mumps through the population takes place through the transference of the secretions of the mouth and nose of those ill with the trouble or coming down with it. The infective agent is most virulent in the early stages of the disease and is present in these secretions as long as there is any swelling of the face. Secondary parties, such as nurses or parents, who have themselves been exposed to a case, rarely if ever, give the contagion to others. Direct exposure to the patient is therefore, responsible for the spread of the infection. Mumps is not borne to others through the air.

"The rules of the State Board of Health require isolation of the patient for two weeks and until one week after the swelling. The child who has been exposed to mumps should be kept home at the first sign of illness in order not to expose others, and any school children when the disease is present in the school should be promptly excluded by the teacher on the first sign of any illness. Only about seventy per cent of persons ever develop mumps. The fact that thirty per cent escape indicate that isolation of the patient and other proper precautions have some value."

FIGHT SOCIETY'S PROPOSAL

(Continued from page 392)

treatment of children is concerned that the homeopaths in very many instances have had very much greater success than allopaths did.

Now, I have nothing against allopaths, because I treat with them at the present time in very many instances; I have very many of them who are my personal friends, and I know that so far as they personally are concerned that they do not care to have a bill of this kind passed, that they are perfectly willing to see the rest of the profession prosper,—the rest of the branches of their profession prosper and to contribute their bit to the healing profession and to society as a whole. It seems to me that the present make-up of the board is representative, and if anything should be done perhaps the osteopaths should be given greater representation upon that board than they now have, if any changes are to be made, in order to even up the distribution. I don't think that there is any injustice to be done as long as you have a balanced board, composed of representatives of these four branches of the healing profession, and I hope that this bill will not pass and that the law will remain as it is at the present time.

Chairman: Anyone else opposed to the bill?

Dr. John E. Rogers: John E. Rogers, Oshkosh, —representing myself. I happen to be the chairman of the legislative committee of the State Association and a member of the Board of Trustees of our National Association,—the American Osteopathic Association. We have been given to understand that the osteopaths were not to be affected in this bill. In fact, that is the information that has been sent out over the state, that there was nothing to warrant the thought even of the osteopathic profession. However, the proponents of the bill state that under this amendment the Governor is free to appoint any number from any school; in other words, he might appoint if he so desired 7 homeopathic physicians, 7 eclectic physicians, or he might perchance appoint 7 allopathic physicians, or he might apportion these schools in any proportion that he might deem advisable. Proponents also state that the predominant school is just as liable to have a minority on the board as any of the schools. Now, under this pretext of liberality the proponents of this bill disguise the fact that with their large proportion of practitioners seeking a license, that they might be able to bring pressure upon the Governor in his appointments upon the presumption that the larger number of applicants of one school demanded a larger proportion of examiners from that one school. In Section 147.16 it is provided that all applicants shall be given the same examination. And on page 5 of the rules and regulations of the State Board of Medical Examiners, it states that, "Candidates intending to practice homeopathy, eclecticism or osteopathy will be examined in materia medica and therapeutics by the members of the board of examiners representing those schools." This provision in Section 147.16 presupposes that at least one representative of the homeopathic school and one of the eclectic school must be appointed, so that the proposition of five members being appointed from the allopathic school,

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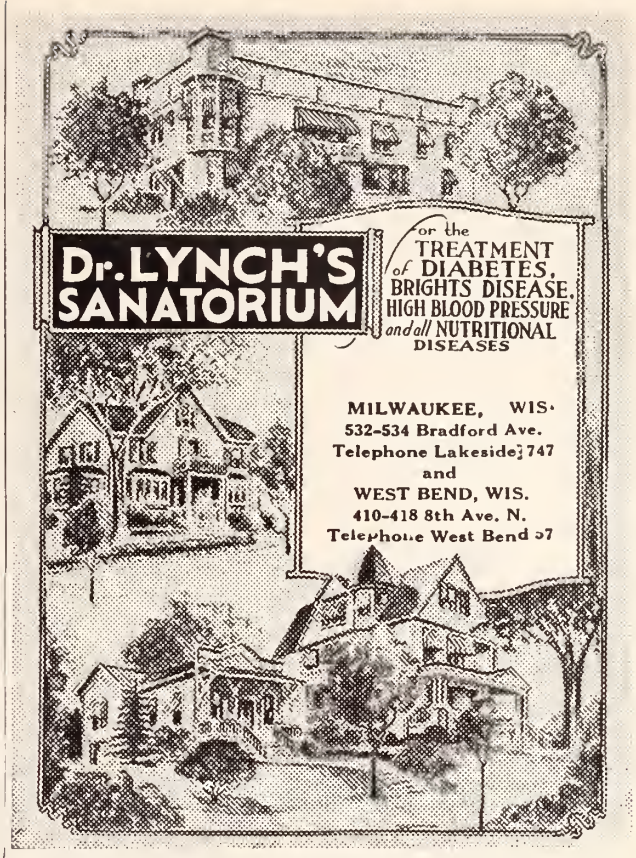

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—this leaves it possible that that might occur. Section 147.17 provides that if 6 members find the applicant for license qualified it shall issue a license to practice medicine and surgery or osteopathy and surgery. It may readily be seen then that in the event of five members of the board being represented from one school, and if any tendency to discriminate exists it would be difficult to secure the required six members to license the licensee. For that reason it is impractical to create any tendency to show partiality to any one school in appointment of members to the board, and also impractical to create a tendency toward domination of any one school. This is the danger point in the bill under consideration. The fact that no difficulties and no embarrassments are obtained in the operation of the board as it is now at present constituted is sufficient evidence that no change is necessary at this time and no change is now warranted. It is therefore my belief that to pass the bill will defeat the very purpose of a perfect democratic method and a continuance of a democratic policy as it is now established in the state.

Mr. Schultz: Edward E. Schultz, Jefferson, attorney representing the Eclectic Medical Society of Wisconsin. I don't believe there is anything further I can say to what these gentlemen before me have said, except that the State Eclectics are absolutely opposed to this bill very nearly to a man.

Madam M. E. Raymond: Mr. Chairman and members of the Committee. M. E. Raymond, Chicago, official legislative representative of the Mid-West Homeopathic Institute, including the State of Wisconsin. I have come primarily to say a good many things which have already been said. Therefore, I will try to repeat as few as possible. While a non-resident of your state, my point of view is that of our united 29 states. As we see the matter, I believe the chief thing that has to be considered is, first of all, what will be the result if this bill becomes a law. You have only to turn to the records of the states that have had such bills and you will find in every state in the United States where they have had a bill of this kind there has been a case appealed to the Supreme Court because of injustice due to balance on one side. In San Francisco in 1928 the Y. M. C. A. made an impartial review of what the sick people want when they want assistance. They surveyed 13 of the Pacific Coast states. They developed the fact that 47 per cent of all sick people sought drugless assistance. You are disqualifying 47 per cent of your Wisconsin people if you put the power in one place here. Now, the Wisconsin laws as viewed by outside states have always represented the people. This is not in keeping with the history of the past. Counsel who introduced the bill made the statement that he believed the result would be better if they were to legislate along modern lines. I have heard a great many interpretations of homeopathy. It is a difficult thing to understand. Yet I believe in a few words I can clear your minds to some extent. Homeopathy literally deals with the law of vibrations and infinitesimals, and is being proven in every scientific laboratory. Your radio within this room is a very good proof. The law of infinitesimals, the releasing of the power of the atom. If there is anything any more modern, I would like to see it. Now, in closing, I want to tell one story. One of the oldest, richest families in America,—the Wendell family of New York—saw fit to leave 35 per cent of one of the greatest wealths ever accumulated to the Flower Hospital in the City of New York, which is homeopathic. We have two large colleges, one in Cleveland and one in San Francisco. The two hospitals running at the present time are graduating 125 and 135, where previously they graduated 65 and 70. In the last two years the homeopathics have increased, not decreased. We are not a tired Marathon racer whose tongue is hanging out, and about to faint and fall out of the race. We are increasing in numbers, increasing in understanding. As a final closing statement I would like to have each one of you individuals ask himself on this bill, would it be comfortable when you are sick—there are always mental aspects entering in—if you want to go to John Brown to be doctored, and the law tells you you have to go to someone else? If this bill becomes a law a sick person will not have the privilege of going to the one he wants, because they will not be practicing. Thank you.

Chairman: Anyone else opposed to the bill?

Dr. Rogers: May I ask those that represent my profession,—the osteopathic profession,—may I ask them to stand at this time, to show you their representation here today.

Chairman: Doctor, if there are any here that don't want to speak on the bill, if they just will leave their names with the Clerk opposing the bill, that would be all right. We leave that entirely up to your representatives here.

Dr. Rogers: Any of those that are here today that were not here last Wednesday, will they leave their names with the secretary at this time, please.

Mr. Mulder: Mr. Chairman and members of the Committee. John Mulder, Assemblyman from La Crosse County. I want to take this opportunity of endorsing every word that my friend and fellow citizen, Lawrence Brody, has told you. Two years ago I introduced a bill for the Medical Society of this State for which I have no regrets; I introduced a bill which I thought was right and just. The bill now before us doesn't appear to me to be fair and just to the citizens of the state of Wisconsin. It is useless for me to go on and tell you why. This has been explained to you by almost every one who has opposed this bill. I am a firm believer in homeopathy. I was vaccinated years ago in a little village in La Crosse County by a homeopath who was sent there by the school board to take care of all the children at that time. Later in life and for a number of years we have had a homeopath to take care of our family. We have

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raised five children, and the majority of these have been taken care of by a homeopathic physician in our city, and I have no regrets up to this time for engaging a man of that type. I am reminded of a little story that happened years ago in a little debating society that we had. I forget what the title of the debate was. There was an old gentleman in very good spirits—this was before the 18th amendment—and he came up quite intoxicated, and he said, "Gentlemen of the jury, this subject reminds me of a jug; the handle is all on one side." And that is the way I think this bill is, too one-sided for the State of Wisconsin to adopt. And I as a member of the Assembly shall oppose the bill.

Mr. Brody: Mr. Chairman, I just want to say this, that I neglected to say, that illustrates better than anything else I know of how balanced this board is at the present time and has been and how fair it is. The present chairman of this Board of Examiners is an osteopath; just before him an eclectic was president; just before him an allopath was president; and just before him a homeopath.

Chairman: Anyone else opposing this bill? We have 6 or 7 other bills before us this afternoon, and I wish you would step up so we can speed this along as fast as possible. We want to give everyone a fair chance to be heard, but we must move along.

Dr. Wolfe: Dr. A. H. Wolfe, (O), Green Bay, Wis. I am here to register my protest against this bill.

Dr. Reay: George R. Reay, (H), La Crosse. I wish to protest against it.

Dr. Runells: Dr. D. S. Runells, (H), Appleton. I wish to protest this bill.

Dr. Britting: Dr. A. H. Britting, (O), Janesville. I wish to protest.

Dr. Haney: Dr. F. C. Haney, (H), Watertown. I wish to register as opposed to the bill.

Others registered were:

Against the Bill: Assemblyman Earl Hall, Tunnel City; Drs. Stanley D. Howe, (O), Racine; K. W. Shipman, (O), Evansville; J. B. Brewer, (E), Member, State Board of Medical Examiners, Jefferson; J. C. Brewer, (A), Jefferson; A. V. Mattern, (O), Green Bay; A. L. Burdick, (H), Janesville; A. U. Jorris, (O), La Crosse; V. R. Carlisle, (O), Kenosha; W. N. Linn, (H), Member State Board of Medical Examiners, Oshkosh; C. D. Meade, (O), Viroqua; J. M. Marsh, (H), Elkhorn; F. C. Haney, (E), Health Commissioner, Watertown; G. E. Crosley, (H), Milton and Janesville; Edith V. Bartlett, (H), Janesville; Velma Walker, Madison, Mary Bartlett, (H), Beloit; W. A. Hazelton, (H), Hayward; J. B. McKnight, (H), Health Officer, Fond du Lac; E. C. Egelhoff, Fond du Lac; Estelle S. Chase, (H), Fort Atkinson; Leone Dalton, (O), Racine; Richard Gordon, (O), Madison; C. W. Parish, (O), Whitewater.

Mesdames M. V. Baxter, West Allis (husband O); George McCammond, Madison, and J. R. Young, Beloit (husband O).

THERAPEUTIC NOTES

In addition to the articles enumerated previously the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

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Swan-Myers Company:
- Mixed Grass Pollen Extract—Swan-Myers.
- Russian Thistle Pollen Extract—Swan-Myers.

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The following products have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion in New and Nonofficial Remedies:

Pollen Extract—Arlco.—The following pollen extracts—Arlco (New and Nonofficial Remedies, 1930, p. 29) have been accepted: Birch Mixture Pollen Extract—Arlco; Maple Mixture Pollen Extract—Arlco; Oak Mixture Pollen Extract—Arlco. Arlington Chemical Co., Yonkers, N. Y. (Jour. A.M.A., March 7, 1931, p. 773.)

Iopax. — Sodium 2-oxo-5-iodopyridine-N-acetate. Iopax contains from 42 to 43.5 per cent iodine. It is proposed for use intravenously in radiographic visualization of the urinary tract. It is also used for injection into the renal pelvis through the ureteral catheter for pyelography. The maximum intravenous dose is 30 Gm. of the powder dissolved in 100 cc. of redistilled water. Schering Corporation, New York. (Jour. A.M.A., March 14, 1931, p. 859.)

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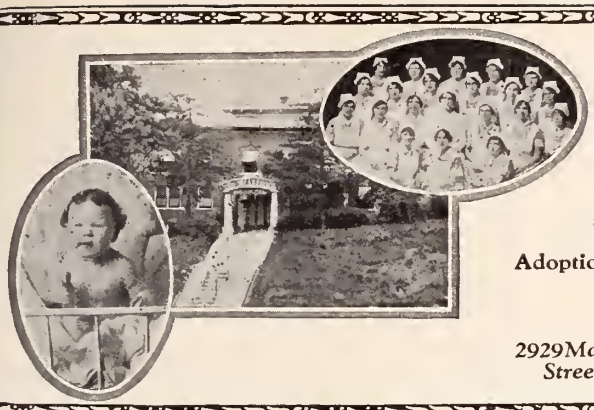

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FOODS

The following products have been accepted by the Committee on Foods of the Council on Pharmacy and Chemistry for inclusion in Accepted Foods:

H-O Oats (Quick) New Style (Hecker H-O Company, Inc., Buffalo, N. Y.) Oat flakes, lightly toasted, cut small and rolled thin to permit quick cooking. The oat flakes contain practically all of the three portions of the groat—bran, germ and endosperm. The product contains: moisture, 8 per cent; ash, 2 per cent; fat, 7.3 per cent; protein, 15.2 per cent; crude fiber, 1.3 per cent; carbohydrates, 66.2 per cent. (Jour. A.M.A., March 7, 1931, p. 773.)

Land O' Lakes Sweet Cream Butter (Land O' Lakes Creameries, Inc., Minneapolis). A packaged, salted or unsalted butter graded by official federal-state butter graders as rating 93 score or higher. The cream used in the manufacture of this butter, the conditions, equipment and process of manufacture, and the final product must meet certain published standards and requirements adopted by the corporation. Before packaging, the butter is graded according to government standards by federal-state butter graders appointed by the U. S. Department of Agriculture in co-operation with the Minnesota State Department of Agriculture. The composition of the salt butter is: moisture, 15.8 per cent; milk-fat, 80.7 per cent; curd, 1 per cent; salt, 2.5 per cent. The composition of the unsalted butter is: moisture, 16 per cent; milk-fat, 83 per cent; curd, 1 per cent. (Jour. A.M.A., March 14, 1931, p. 861.)

Knox Plain Sparkling Gelatine (No. 1) (Charles B. Knox Gelatine Company, Inc., Johnstown, N. Y.). An unflavored, unsweetened granular gelatin. Knox gelatine is not chemically bleached not does it contain preservatives. Strict sanitary control is exercised in the manufacture. The composition is: moisture, 13 to 14 per cent; ash, 1 to 1.2 per cent; protein, 85 to 86 per cent; fat, 0.1 per cent; arsenic as As_2O_3, 0.6 parts per million; copper as Cu, 2.5 parts per million. Knox gelatine contains no sugar or added flavor. It is one of the most readily digested proteins.

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Velveeta (Kraft-Phenix Cheese Corporation, Chicago). A delicious cheese food. Kraft Process American Cheese with added milk sugar, milk minerals and water. A cheddar cheese admixed with cream (or butter and skim milk powder), milk-whey powder and salt. The approximate composition is: moisture, 44 per cent; ash, 6 per cent; fat, 25.5 per cent; protein, 18 per cent; lactose, 6.3 per cent; calcium, 0.53 per cent; phosphorus, 0.71 per cent; 75 mg. of Velveeta is equivalent to 10 mg. of butter in vitamin A potency. Velveeta is claimed by the manufacturer to be richer in milk minerals and lactose than the usual cheeses not containing the milk-whey. (Jour. A.M.A., March 21, 1931, p. 947.)

Ampules Emulsion Mesurol, 20 per cent, 1 cc.—A suspension of mesurol (New and Nonofficial Remedies, 1930, p. 100) in sesame oil, each cubic centimeter of which contains mesurol equivalent to from 0.103 to 0.117 Gm. of bismuth. Winthrop Chemical Co., Inc., New York.

Tablets Theocin 1½ grains.—Each tablet contains theocin (New and Nonofficial Remedies, 1930, p. 415) 1½ grains. Winthrop Chemical Co., Inc., New York.

Ampules Mercurochrome–H. W. & D., 1%, 10 cc.—An aqueous 1 per cent solution of mercurochrome–220 soluble (New and Nonofficial Remedies, 1930, p. 271) stabilized with ammonium hydroxide; in 10 cc. ampules. G. D. Searle & Co., Inc., Chicago.

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Diphtheria Toxoid-Cutter.—Diphtheria Toxoid-Cutter (New and Nonofficial Remedies, 1930, p. 485) is also marketed in packages of one 45 cc. vial. Cutter Laboratory, Berkeley, Calif.

Synthetic Thyroxine.—It contains not less than 65 per cent of iodine. It has the actions and uses of thyroxin, U. S. P. (New and Nonofficial Remedies, 1930, p. 403). Synthetic throxine is supplied in the form of ampules containing 1.1 cc. of solution containing 1 mg. and in the form of a solution, each cc. containing 2 mg., and in tablets containing 1 mg. Hoffmann–La Roche, Inc., Nutley, N. J. (Jour. A. M. A., August 16, 1930, p. 485)

Antimeningococcic Serum. — Antimeningococcic serum (New and Nonofficial Remedies, 1930, p. 350) marketed in packages of two 15 cc. syringes with apparatus for intraspinal injection; in packages of one 50 cc. double-ended vial with apparatus for intraspinal injection. National Drug Co., Philadelphia.

Mercurochrome Suppository–Aces. — Suppositories representing a 2 per cent solution of mer-

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curochrome–220 soluble (New and Nonofficial Remedies, 1930, p. 271) in a slightly aromatized, hydroglycero-gelatin base; each suppository weighs approximately 6.5 Gm. (100 grains). Aces Laboratory, Inc., Brooklyn, N. Y. (Jour. A. M. A., August 23, 1930, p. 594)

White's Cod Liver Oil Concentrate.—A cod liver oil concentrate in the form of tablets (wafers), each containing not less than 250 vitamin A units and not less than 100 vitamin D units. White's cod liver oil concentrate possesses properties similar to those of cod liver oil so far as these depend on the fat soluble vitamin content of the latter. White Laboratories, Inc., Gloucester, Mass. (Jour. A. M. A., August 30, 1930, p. 663)

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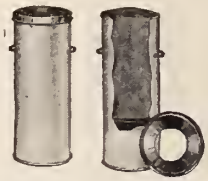
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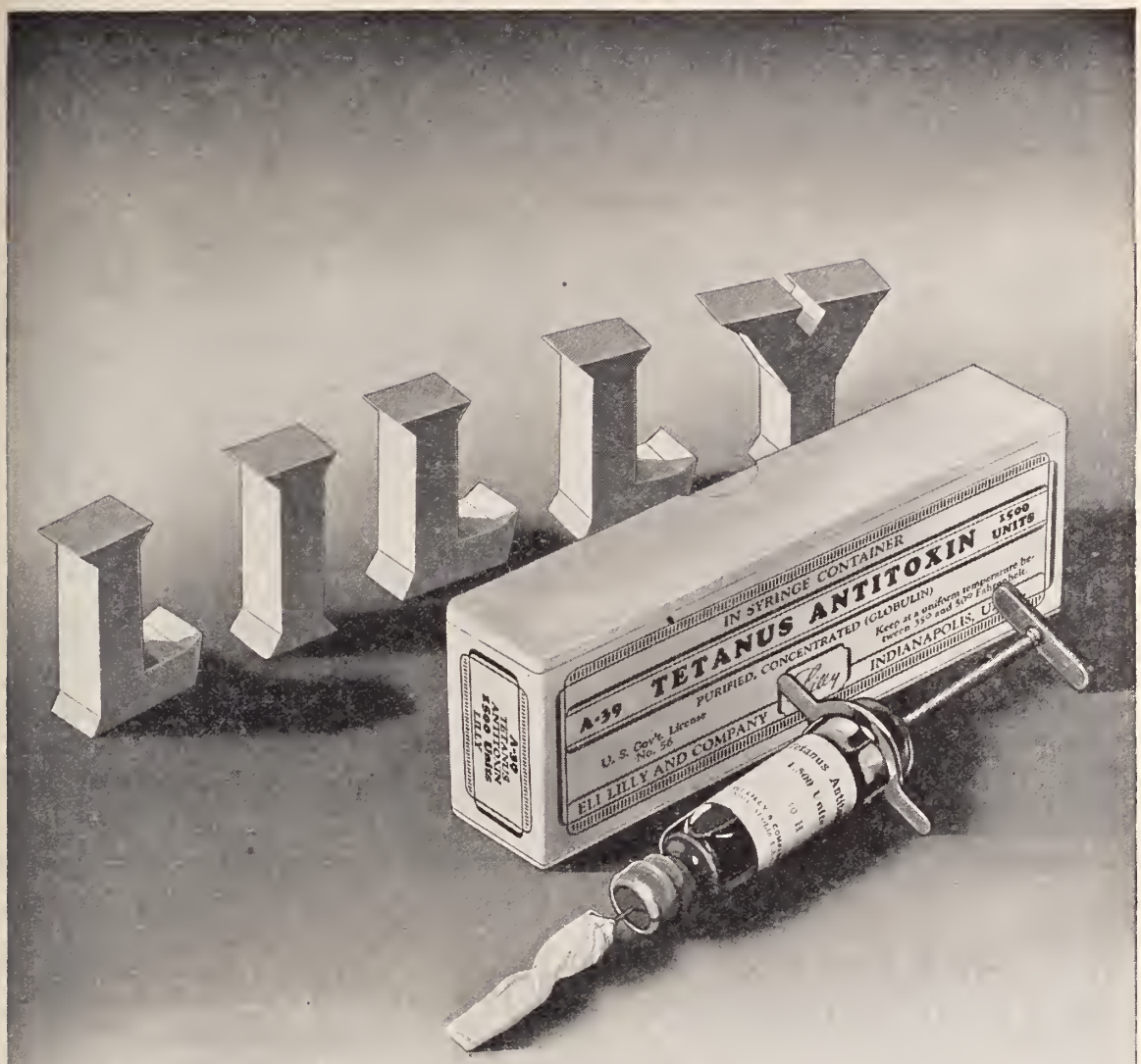

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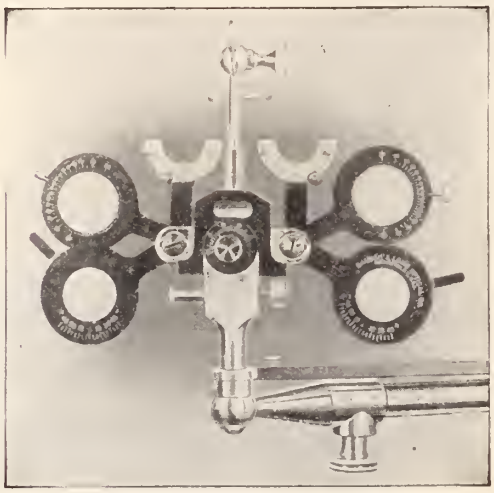

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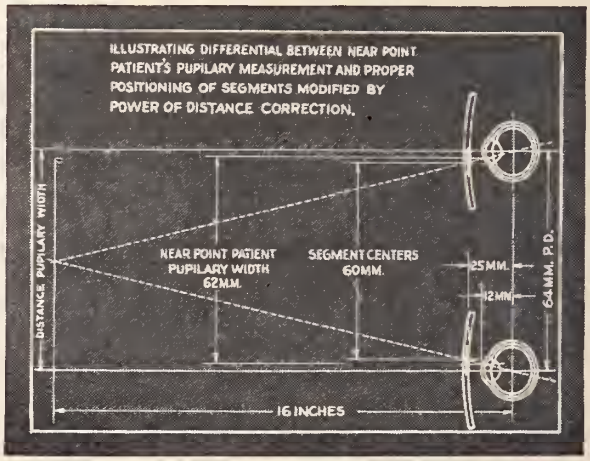

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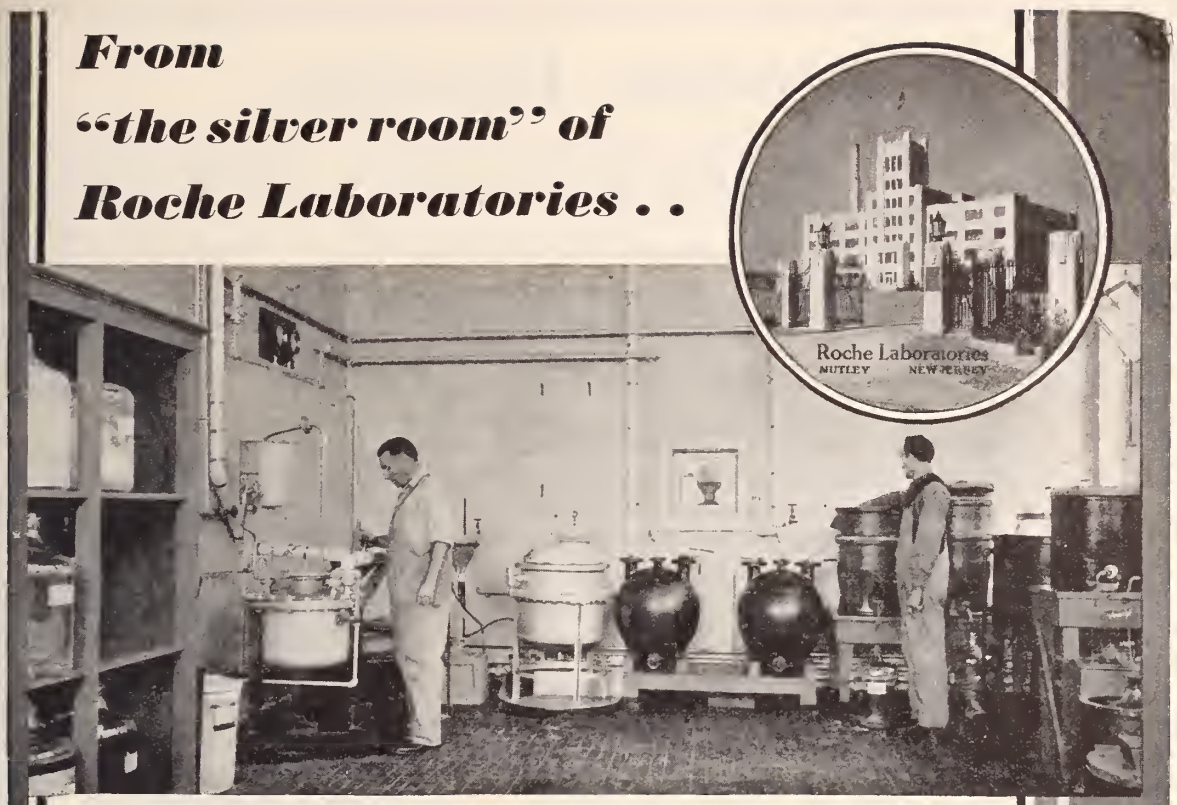

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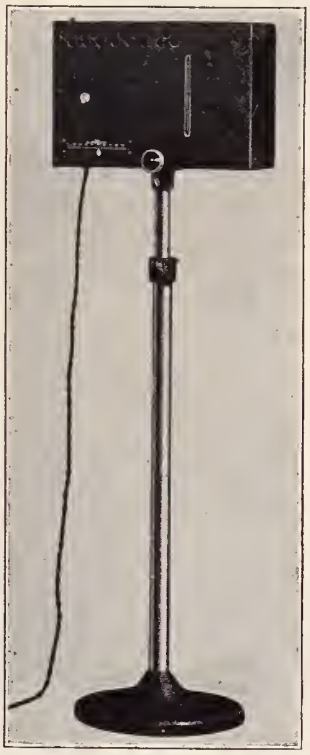

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The Prostate of Middle Age*

By H. E. KASTEN, M. D.
Beloit

All periods of life are of equal importance to the individual but it is during middle age that the individual is of greatest importance to society.

The middle age period has been selected for consideration because it is during this time of life that one notes the appearance of those maladies which have the most important bearing on the length of life of the individual and upon the well being and efficiency of old age.

The first three decades of life mark the period of growth and development and are marred by the infections and accidents of youth. Many of the infections leave the individual none the worse for having had them, while the remainder leave the organism sufficiently damaged to cause trouble in later years. Together with the sequalae of the diseases and accidents of youth, we find in middle age another great group of disturbances known as the degenerative diseases. The last named group of diseases are insidious in their onset and are responsible for a high percentage of early deaths and early disabilities, relative or complete.

Nearly all these disease processes are most amenable to treatment during their early stages at the time when the evidence of their presence is first manifested. In the majority of these conditions, if they have become well established or advanced, therapeutic measures can only serve as a means of checking the progress of the disease, or counteracting its deleterious effects.

It is during middle life that the majority of individuals attain their period of greatest usefulness and value to the community, many of them holding positions of great responsibility so that their health and strength is of the greatest importance to themselves and their families, and frequently to numerous others—even at times the welfare of an entire nation being dependent on the state of health of an individual.

It is, therefore, meet and proper that this group of middle aged men should receive the most painstaking and careful consideration of their physician, who should earnestly urge their reporting for frequent observation and study to the end that he may detect the beginning of disease, the early effects of the stress and strain of business and social life, or the early manifestations of previous disease or injury, and that he may be able to direct and advise the individual along lines of conduct and therapeusis so that the deleterious influence of these factors, or disease processes, be avoided, overcome or ameliorated.

The prostate has been chosen for consideration, not because there are new and startling truths to be presented, but rather to bring to mind old and forgotten facts, presenting them anew in the light of modern clinical observation with the hope that their importance in the life of the middle aged man may be fully appreciated and that an interest may be stimulated among clinicians to more carefully study this very important organ in patients of this age period.

The prostate, because of its anatomical position at the outlet of the genito-urinary tract, and, because of its function as an important sexual organ, occupies a unique position in the scheme of man's physical and mental welfare. Being constantly subjected to possibility of infection,—as will be shown later,—and frequently traumatized by excesses or irregularities of sexual life, it is no small wonder that it becomes diseased in an alarming high percentage of men.

What is more tragic than the prostatic of late middle life who constantly voids or cannot void at all? Even more tragic is the

* Presented before 89th Anniversary Meeting, State Medical Society of Wisconsin, Milwaukee, September, 1930.

mental status of man of early middle age who believes that he is, or actually is, sexually impotent.

The physician who fails to make a careful and adequate vaginal examination in his middle aged female patients, or a careful and adequate prostatic examination in his middle aged male patient, irrespective of the presence, or absence of symptomatology pointing to these organs, is guilty of culpable and inexcusable professional incompetency.

Fortunate is the physician who has "eyes" in his finger tips for nowhere is this qualification as indispensable. The x-ray and microscope and the cysto-urethroscope have lent important visual aids in diagnosis, but the digital examination will always remain our most important, readily available procedure in prostatic diagnosis.

Time will not permit of a complete presentation of all the various manifestations of prostatic abnormalities in middle aged man. Nor will it permit of a review of all pertinent facts, ancient or modern, regarding the subjects that have been chosen for this discussion. A few outstanding conditions have been selected which will be presented briefly in an attempt to draw attention to certain newer clinical conceptions and to stress the importance of early recognition of these conditions in patients between 40 and 70 years of age, by the employment of adequate diagnostic measures. It is not to be inferred that the conditions to be presented are in any sense peculiar to, or characteristic of, middle age.

INFECTIONS

The frequency of infections in the prostate in middle age as reported by clinical observers is astonishing. It is a safe estimate to say that approximately 20 per cent of all males during the early part of middle age have infected prostates and that during the latter half the incidence of infection increases to about 40 per cent. From a status of obscurity and neglect the prostate, as a focus of infection, has attained first rank and alert clinicians are giving it the same careful scrutiny that they accord teeth, tonsils, sinuses and other common sites of infection. More important among the causes of prostatic infection we find:

1. Urethritis—specific and non-specific.
2. Acute infectious diseases as typhoid, influenza, pneumonia.
3. Metastatic infection from distant foci through the blood stream and lymphatics.
4. Sexual abuses.
5. Descending infection from upper urinary tract.
6. Disuse,—stasis and faulty drainage is believed to make the prostate a fertile field for bacterial growth.

Acute infections are rather infrequent in this age group and when they do occur are characterized by unmistakable urinary symptoms and hot, firm, and intensely painful prostates.

In the majority of cases, chronic infections are obtained in middle age. The vast majority of cases do not present symptoms that are directly referable to the prostate. Urinary disturbances are often late sequelae to a long standing condition.

Unfortunately the early morbid processes often give little or no local symptomatology and are for that reason often over-looked. Only by careful and adequate routine examination can these cases be detected early.

The infected prostate presents no characteristic feeling to the palpating finger. The entire gland frequently presents a soft flabby, doughy, mass. In some cases the gland is irregular with here and there soft doughy areas. Frequently the entire gland feels normal, and it is only in the microscopic examination of the contents, that are usually expressed with difficulty, that the true status of the condition of the prostate is recognized. It is in the latter type that infections are most frequently overlooked. A cursory inspection of the prostate is utterly fallacious and it frequently requires repeated investigation to establish the guilt or innocence of the prostate. The most usable and reliable diagnostic procedure is digital examination and complete laboratory examination of the expressed material.

Acute fulminating infections are rare in this age group and are treated conservatively

by bed rest and sedatives. When abscesses occur surgical intervention may be necessary.

The vast majority of prostatic infections in this group are chronic. In the hands of some workers diathermy has yielded excellent results. However, the treatment of choice among most urologists is massage, dilatation and instillation of one of the silver preparations. The trite saying "Know a few drugs well" is in order here.

CALCULI

Stones in the prostate are more likely to be encountered by the pathologist than the surgeon. In Bellevue hospital (Lowsleys) (1) in 250 prostates taken from subjects of all ages calculi were found in about one-fifth of the specimens examined.

Probably calculi formation here, as in other parts of the body, is due to faulty drainage and infection.

Cases of prostatic calculi often give a history of prostatic pain, abscess formation, and passing stones. Calculi, however, are painless as a rule and are usually found when searching for some other lesion of the genito-urinary tract. Kretschmer states that there is a great induration of the entire prostate so that it feels as "hard as a stone". He adds further that increased consistency of the prostate during early adult life should arouse one's suspicions of the presence of calculi, whereas in older persons increased consistency may be significant of malignancy. Our surest diagnosis is radiography.

Symptomless calculi discovered in routine radiography had best be left alone. When symptoms are produced, surgical removal is indicated.

TUBERCULOSIS

Tuberculosis of the prostate is practically always secondary to lesions elsewhere in the body and occurs usually in the early decades of life when the incidence of tuberculosis is highest. It does occur after the age of 40 often enough to warrant its inclusion for consideration in the middle age group.

Primary tuberculosis of the prostate is exceedingly rare. The anatomical location of the prostate with relation to other genito-urinary organs accounts for the frequent occurrence of prostatic tuberculosis in conjunction with lesions elsewhere in the body. Bothe (2) reviewed the literature and found that 65 per cent of genito-urinary tuberculosis showed associated lesions in the prostate. A strange coincidence has it that an equal percentage showed associated lesions in the lungs. The inference to be made is, of course, that genito-urinary tuberculosis is largely secondary to other lesions in the body.

Tuberculosis of the prostate, though rather rare in middle age, is mentioned here only to draw attention to the danger of attempted treatment should it be unrecognized. Massage of a prostate with a tubercular infection is exceedingly dangerous.

Cases of acute miliary tuberculosis following the massage of tuberculous prostates are on record. The diagnosis of tuberculosis of the prostate by digital inspection alone is practically impossible owing to the fact that there are four phases in the evolution of the disease process. Hesse (quoted from Youngs Urology) (3) classifies the changes thus:

1. Stage of tubercle formation.
2. Stage of confluence of tubercles with caseation and abscess formation.
3. Encroachment upon the periprostatic tissue and the whole body as miliary tuberculosis.
4. The stage of healing.

Obviously the digital findings vary according to the stage of the disease. It is therefore very good policy to be exceedingly cautious in the treatment, especially massage, of an infected or hypertrophical prostate in the presence of suspected or demonstrable tuberculosis anywhere in the body.

In as much as tuberculosis of the prostate is usually associated with tuberculosis of the remainder of the genito-urinary tract such as the seminal vesicles, bladder, ureters, and kidneys, and often with lesions elsewhere in the body, the treatment presents great difficulties. It is too detailed to permit of presentation here and special works on the subject should be consulted.

PROSTATIC OBSTRUCTION

Obstruction of the urinary tract by prostatic abnormalities is one of the great tragedies in the lives of men of late middle and old age. Approximately 34 per cent of men over 60 years of age have hypertrophied prostates and of this number 50 per cent have obstructive symptoms.

In spite of greater care in the determination of the physical status of the patient, refinement in surgical technic and proper preoperative preparation of the patient, our operative mortality is still alarmingly high.

Is there no ray of hope anywhere and are men doomed to look ruefully into the future toward the approach of old age and its grim consort — prostatic hypertrophy with its physical torture and mental anguish? The etiology of benign prostatic hypertrophy has engaged the attention of pathologists and clinicians for many years but has resulted only in fruitless argumentation.

Divergence of opinion as to the underlying pathology is along two lines, one that prostatic hypertrophy is due to multiple adenomatous growths while the other theory is that prostatic hypertrophy is a hyperplasia particularly of the urethral portion of the gland in response to the stimulation of the products of long standing inflammation.

The former theory has for its proponents the majority of French and German pathologists and many Americans as well. On the other hand, Gardner in Cabots Urology states "The tendency of American urologists and pathologists is to consider the usual enlargement of this organ as an inflammatory hyperplasia."

In support of the latter theory which offers some hope for the prevention of prostatic hypertrophy is found the eminent pathologist Adami. Hugh Young (3) states that in his opinion "the process is a hyperplastic one" and adds that "it is not known what initiates hyperplasia." Other writers are impressed with the theory of inflammatory hyperplasia. Ballenger (4) and Caulk (5), individually, think that the hyperplasia is due to the irritant character of the products of inflammation. Von Lackum and Mitchell (6) discuss congestion and state that it is an early stage in the development of prostate inflammation and enlargement.

Several writers present series of cases which tends to show that massage relieves the patient of symptoms. Ballenger (4) thinks that if local treatment is started early enough hypertrophy may be avoided, and Caulk (5) cites 100 cases of prostatism, many with obstruction, which were relieved completely by simple local therapy. Some have been observed for 10 or 15 years without recurrence. Whether massage benefits the inflamed edematous, congested and painful prostate by removing the irritant products of the contained secretions, or by improving the circulation, thereby bringing to the prostate more of the naturally protecting substances, cannot be definitely stated. It is highly probable that both drainage and improved circulation are mutually helpful.

The exact status of inflammation as a causative factor in prostatic hypertrophy will have to be settled by pathologists and clinicians of the future.

However, in this conception of the etiology of prostatic obstruction there lies a ray of hope that should appeal to both physician and patient alike. Caulk (5), in his address delivered before the section on urology of the American Medical Association, 1929, said "I would suggest that physicians pay strict attention to the prostates of middle life and protect them from insidious infection. The prostate must be examined as a part of a general examination. Not only should it be palpated but its secretion should be expressed and microscopically studied. Some of the softest and smallest prostates possess the most purulent secretions. In so doing the majority of persons may be spared any type of surgery and if early obstructions become manifest they should be dealt with by means of lesser surgery and not allowed to progress."

MALIGNANCY

Cancer of the prostate is no longer considered an infrequent disease. The percentages of malignancy in prostatectomy specimens, as reported by various observers, varies from 13 to 21 per cent. These statistics show that cancer of the prostate is a fairly common disease and that the early recognition is a very

important problem in effective surgery of the prostate.

The etiology of cancer of the prostate, like cancer elsewhere, is obscure. It makes its appearance after forty and is very frequently associated with hypertrophy. The greatest frequency of cancer is in the sixth and seventh decades of life, about 50 per cent appearing in the latter decade.

Because both hypertrophy and cancer appear in about the same age period it is very difficult to make a differential diagnosis even at operation. However, any prostate of middle aged patients that presents an area or areas of induration amounting to stoney hardness entirely out of proportion to what we would expect in tuberculosis or prostatic calculi, should make us think of cancer.

A complete discussion of the symtomatolcgy and diagnosis cannot be gone into in a presentation of this kind. Attention can merely be directed to the theme of this paper, —careful routine, adequate examination of the prostates of middle aged individuals.

MALE CLIMACTERIC

This subject, while it has little or no bearing on the prostate, is of such overwhelming importance in the life of many middle age men that its inclusion seems justifiable.

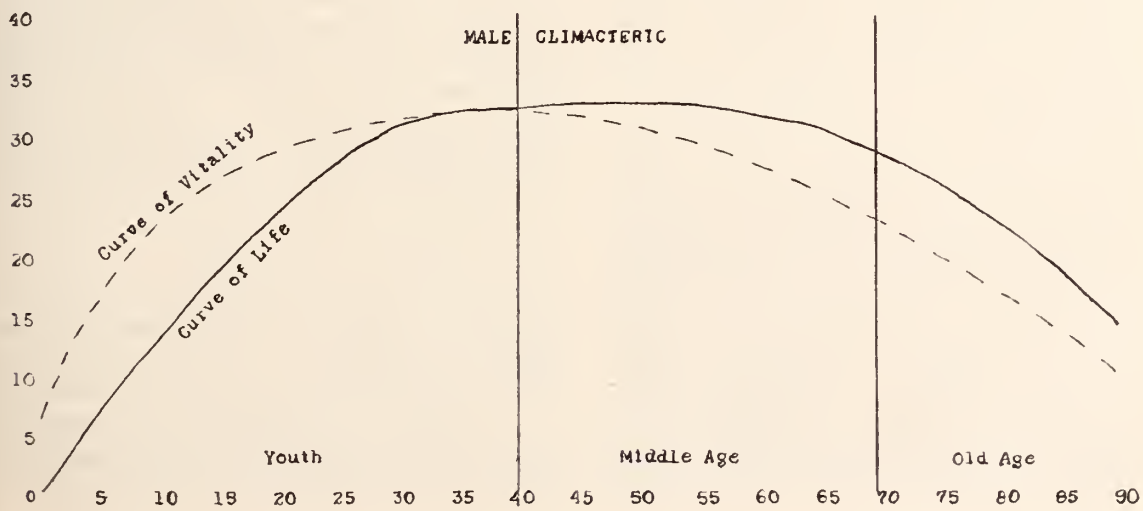
Certain physical and mental changes in man occurring most frequently between the ages of 45 and 55 comparable to the climacteric in women were noted by Sanctorius as early as 1728.

This clinical conception has received at the hands of the rank and file of American physicians at least, but scant recognition, although the foreign literature and lately the American as well, is voluminous on the subject.

The difficulty has been that we have been led to believe that the conditions in the male climacteric and the female climacteric are analogous. Too much attention has been centered on ovarian changes in the female climacteric and the lack of demonstrable change in the gonads,—the analogous organ in the male,—in the so-called male climacteric with the result that the whole proposition has received unjustifiable discredit in the minds of the majority of physicians.

When we realize that the sexual element is only a part of the symptom complex and in no sense a causative factor, then we are in a position to discuss the merits of the clinical entity,—the male climacteric.

If we may graphically represent the active life of the male with its various ramifications and its dominant components and designate it as the life curve and then if we may graphically represent the flow of physical vigor and vitality as the vitality curve, we will find that in the majority of normal males these two curves begin to rise from the time of birth. During youth the vitality curve makes its sharpest rise and is notably higher than the life curve. It is here that we encounter the juvenile problems of flaming youth. In the latter part of the youth period and in the early part of middle age,



the life line has ascended sufficiently so that the two curves run together. It is here, that we say, that a young man has settled down, and accordingly lives harmoniously. If these two curves run together for the balance of life time, then middle age and old age are devoid of internal strife.

The group of males here especially considered do not go through life in this ideal manner. It is a physiological fact that the curve of vitality reaches its highest point somewhere before the age of 45 years, and then in the periods between 45 and 55 years of age there begins a symptom producing decline. The curve of life, however, with its heritage of past experiences and memories, its future hopes and ambitions, often continues its upward trend. The parting of these two lines, one representing decreased vitality, the other representing continued or increased life endeavors, marks a climax in the lives of a great number of men. The resultant mental and physical conflicts give rise to a condition which we choose to call the male climacteric.

The component elements of this period of strife, or as Schwartz (7) calls it, the period of balance establishment, are mental and physical, with sexual aberrations often dominating the latter group.

In short, these men realize that they are losing their physical stamina and drive, the so-called "pep". They sense their declining vigor in terms of being unable to enjoy pleasures as in the past. They no longer feel equal to the demands that their present work, whether mental or physical, exacts, and they feel that they cannot meet the responsibilities of future endeavors and responsibilities. They experience early and disabling fatigue.

Objectively a number of physical changes in the individual may be noted. There is less spring in the step, less warmth in the handclasp, in fact there is a notable reduction of enthusiasm in the whole general demeanor. The outstanding physical change, as stressed by German writers, is a tendency to the accumulation of fat. It is a common impression that the increase in fatty tissue is analogous to the fatty change which is usually conspicuous following the female climacteric. There is no evidence, however, that the two manifestations are biologically identical.

Should any type of sexual aberration, especially impotence, supervene, the entire complex immediately assumes tragic proportions.

The mental disorders that manifest themselves during and after the male climacteric are often more serious than the physical, and vary all the way from minor changes in man's character to a melancholia terminating in suicide.

Chief among the mental disorders is the loss of precise memory for recent events. There is often loss of self control which leads up to emotional and hysterical conditions. Inability to sleep is a major complaint together with mental tension and irritableness during waking hours.

Frequently there is anxiety, inability to concentrate, pessimism for the future which frequently results in a melancholia, driving the individual to take his life.

The most distressing manifestations are deviations from the normal vita-sexuales. These range all the way from marked hypersexual urge to complete impotence. The latter manifestation is the complaint of the majority of patients of this group who present themselves for treatment. Many will grimly struggle through the mental and physical chaos uncomplainingly but when the sexual powers are lost they become genuinely alarmed.

These men have, at the hands of the majority of physicians, been dubbed neurotics and unceremoniously dismissed with the admonition to forget their fancied trouble, the physician being ignorant of the fact that these men were very sick indeed, and that they needed advice and counsel more than ever before in their lives.

How may we as physicians be of help to these genuinely sick patients?

The gaining of the patients absolute confidence is of greatest importance not only from the standpoint of treatment but from that of diagnosis as well. As to treatment it is, briefly, this. Employ such means as we can to lower the curve of life and at the same time raise the curve of vitality.

The precise means to this end are theoretically obvious, yet the fact remains that in their practical application we encounter one of the most difficult problems in the entire realm of medicine.

It is unnecessary to go into the matter of the various avenues of approach that a resourceful and tactful physician may employ in his therapeutic endeavors.

Attention can only be called to one outstanding phase of the problem.

All physicians are well aware of the role that infection plays in undermining the vitality of the human body. They are also well aware of the importance of eradicating all demonstrable foci of infection. It is, however, not so generally known that the prostate is the site of infection in a surprisingly high percentage of middle aged males. The observation drawn from the authors experience is that 90 per cent of all cases presenting the symptom complex under discussion had infected prostates and that appropriate treatment of this organ was of great value in the general handling of these cases.

Many of these cases have fallen into the hands of irregular practitioners who by virtue of tactful handling have carried these invalids through the distressing period and derived credit and recompense for a cure which physicians have disdainfully thrust aside.

SUMMARY

All ages are of equal importance to the individual but the middle age is the period that the individual is worth most to society.

Middle age presents the manifestation of diseases or accidents of youth and the inception of the degenerative processes of later life.

The prostate, because of its antomical position at the out-let of the genito-urinary system and because it is an important sex organ, plays an important role in the drama of life.

Careful and adequate examination of the prostate, backed up by complete laboratory examination of the expressed material should be an integral part of every physical examination of men of middle age.

The examining physician should be mindful of a number of prostatic conditions which, though not peculiar to middle age, appear sufficiently often in this age period, so as to make their early recognition and proper treatment of inestimable value to the health and welfare of individuals between the ages of 40 and 65 years.

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OBSTETRICS COURSE

The course in Obstetrics and Gynecology, announced in The Journal last month, will get under way on June 15 and be in force through the summer at six centers in the eastern counties. This course fulfills the Society's plan to bring to physicians in their home districts a high grade clinic program on this subject. Registrations may be made now by writing to the University Extension Division at Madison or by signing up at the first lecture in any designated center.

The classes will consist of a two-hour session given one day each week for twelve weeks in each of the following cities: Appleton, Green Bay, Manitowoc, Marinette, Oshkosh, and Sheboygan. Physicians may attend at any city they prefer, and, if necessary to miss a meeting, may report in the same week at any other city where the course is scheduled.

The instructors, eminent in their fields over many years of practice and teaching, are Dr. Everett D. Plass, of the State University of Iowa, and Dr. Otto H. Schwarz, of Washington University, St. Louis, Mo.

Focal Infection in the Prostate and Seminal Vesicles*

By W. E. BANNEN, M. D.
LaCrosse

I am presenting this paper, not with the thought of calling attention to a new pathological condition, or one that is rare, but judging from the number of cases that have been diagnosed and treated with marked improvement and recovery, seminal vesiculitis and prostatitis is a subject well worth time spent in its consideration. This is especially so, since many of these cases had been examined quite thoroughly, and had considerable treatment without having had an examination to reveal the presence of prostatitis and seminal vesiculitis. I am afraid that a great number of the men in general practice, and also in the specialties, forget the urologic tract as an important focus of infection.

It is not the purpose in this discussion to go into details, either in case histories, or tables of cases with microscopic and cultural findings, but I hope to present general facts, factors, and statistics, and to stimulate a discussion that will add interest and will urge physicians in general practice to make a more careful examination, diagnose these cases, and give better treatment to these unfortunate individuals afflicted with seminal and prostatic infection. The knowledge of diseased conditions resulting from focal infection is so common, that to mention teeth, tonsils, or sinuses is commonplace, but the remote organs, as the prostate gland and seminal vesicles as a focus of infection, and giving rise to very decided local and systemic pathological conditions is also quite common. The prostate, verumontanum, seminal vesicles, epididymi, and testes, making up one of the most complicated functional systems in the body, are also subject to infection, either direct, which we all know is a very common extension from a urethritis, or secondary to some distant source following infection by lymphatic and hemogenic routes, and it is a common experience, that many cases of arthritis, lumbago, sacroiliac diseases, sciatica, and vague or distant abdominal pains are improved, or cured by proper treatment of infection found in the urologic tract.

The knowledge of these infections is not recent, as medical literature reveals studies of the infections of the prostate in 1815 by Longeau; in 1838 by Verdier; and in 1836 Lalemand noted mental and nervous diseases, classified as neurotic, showing marked improvement following treatment of the prostate glands and seminal vesicles. Twenty years ago Young, Geraghty, and Stevens stimulated the interest of the medical profession in this tract as a focus of infection, and we note a continued accumulation of a large amount of clinical and scientific data that cannot be ignored.

ETIOLOGY

It was commonly believed for a long time that all cases of prostatitis and seminal vesiculitis were of venereal origin, and as statistics are examined and compared with our own clinical cases, the conclusion is formed that many of these cases are non-venereal and not gonorrheal in origin. I will quote a few statistics so collected to bear out this statement. Von Lakum states that in 1667 cases 74 per cent gave a history of venereal infection, while in 500 more recent cases this dropped to 57 per cent. Wolbarst's statistics show that 60 per cent of the male population have had gonorrhea in some form at some time, and concludes that the gonococcus has a pretty definite roll in at least 60 per cent of the vesiculitis and prostatitis cases. Many of these cases when examined may have had an origin, or an etiological factor in the gonococcus, but have become mixed infections and the gonococcus has disappeared from the scene. Certain it is that the greater number of smears and cultures show definitely a variety of organisms, streptococcus, staphylococcus, and others, but no gonococci Other etiological factors are mentioned, such as local trauma. We recently saw a prostatic abscess due to trauma of the perineum by repeated blows from an axe handle while the patient was sharpening fence posts. Another severe prostatitis was precipitated by

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trauma to the perineum by the toe of a boot.

Other etiological factors worth mentioning are engorged conditions due to sexual perversions, sexual continence, and there is a possibility that these play a greater roll than some of the old and long standing gonorrheal infections. Infections may reach the prostate and vesicles by three routes,—through extension from the urethra and rectal wall, through the blood stream, and through the lymphatics. Von Lakum thinks that approximately 40 per cent is blood stream infection, secondary to apical abscess, alveolar and tonsillar infections. Bugbee reported five cases following influenza infection. Wear, after a careful study, states that the most common organism found in his cultures is the streptococcus, or a mixed culture of staphylococcus and diphtheriods. Numerous investigators have found the bacillus coli and staphylococcus to be the chief bacterial offenders. Granting that urological infections are quite common, the next problem to confront us is their probable routes of spreading, that would account for the symptoms that accompany them, that is the anatomical analysis to explain the pathology present. Visher has pointed out splendidly the lymphatic routes from the prostate and seminal vesicle, showing the lymphatics emptying into the lymph-nodes in the hollow of the sacral promontory, and into the iliac group of glands. Morris has injected the prostate and filled the entire chain of nodes to the renal artery, and shown that lymphatics of the prostate are anastomosed with lymphatics from the bladder, vesicles, vasti, and rectum. It is a well known fact that carcinoma of the prostate has early metastasis in the sacrum, ilium, and lumbar and dorsal vertebrae. Great numbers of cases of prostatitis and seminal vesiculitis show marked arthritic changes in this portion of the sacral and lumbar vertebrae, and this anatomically explains the common symptom of backache, or lameness in the lower back in cases of prostatitis and seminal vesiculitis, and also why the orthopedist is showing great interest in these foci of infection. It is not only these, but the cases that present *definite problems in industrial injuries* that may be classed as prostatic backache—a disability following injury, as described in 1928 by Boles.

Organisms occurring in cultures of 100 cases; bacillus coli 24, hemolytic streptococci 13, cultures sterile 63. Of 48 cases, of staphylococcus in 38, and gonococcus in five. These citations merely show the variety of organisms found and often these cultures show but mixed infection.

CULTURES-SECRETIONS

Bacillus Coli	24
Hemolytic Streptococci	13
Negative	63
Staphlococcus	38
Gonococcus	5

SYMPTOMATOLOGY

If the accusation, that seminal vesiculitis and prostatitis is not recognized and not looked for in cases that have had careful investigation of the teeth, tonsils, sinuses, and gastro-intestinal tract, while the prostate and seminal vesicles are overlooked, forgotten, or excluded, it would seem necessary at this time to present in a clear, concise way, symptoms that indicate prostatic infection and warrant a careful examination, or repeated examinations, if the first examination fails to reveal pathology. From the data mentioned, that 60 per cent of patients have a gonorrheal background, or history, such history must need call for a careful examination and exclusion of 60 per cent of our cases. In taking the history diagnostic symptoms may not be outstanding, but there will always be one or more that demand further investigation. Of these, urethral discharge, anything from slight moisture, a morning drop, or glueing of the meatus, to a distinct and definite urethral discharge. This is probably the most common symptom of prostatitis and seminal vesiculitis and may be a symptom of long standing. The discharge may be noted only at defecation. The second most common symptom is urinary disturbance. This may include many or all urinary symptoms from pelvic discomfort, micturia, nocturia, dysuria, pyuria, hematuria, and enuresis. There may be marked variation in the starting, stopping, and volume of the stream. Only *one of these symptoms* may be present or many of them. The third common symptom is urethral discom-

fort, which may be deep seated discomfort, soreness, or pain, and this discomfort may be referred to the testes or to the glans. The fourth symptom, quite common and constant, is low backache. Perhaps no other symptom with the exception of headache has caused more embarrassment to the medical profession than backache. Wesson, Boles, and Player have very ably pointed out this relation and have compiled statistics from x-ray examinations of a large number of so-called prostatic backache, causing prolonged disability and osseous changes, many of these cases complicating industrial disability. The orthopedic section of the Cleveland Academy of Medicine recently held a symposium on low back pain and pointed out the importance of prostatitis and seminal vesiculitis as an underlying cause. Garvin estimates that 75 per cent of the low back pain in the male, during the third and fourth decades of life, is due to chronic prostatitis. With these statistics in mind, we as physicians, certainly must, when confronted with a low back pain in the male, carefully exclude prostatitis and seminal vesiculitis, and if we do not, we are in the same class of quackery and mal-treatment as the chiropractor. The referred symptoms are numerous and may be rheumatic in character, arthritic, neurotic, abdominal, general, and sexual. The abdominal pains may simulate gall bladder disease or gastro-intestinal pathology.

CASE HISTORY

J. G. presented himself with symptoms simulating gall bladder disease and renal colic. He had had a very careful gall bladder visualization, gastro-intestinal barium studies, and cystoscopic examination with pyelograms, all of which had been negative. Examination of the seminal vesicles and prostate revealed definite pathology. Smears obtained contained clumps of pus and showed mixed infection of bacillus coli and staphylococcus. The examination of the oral cavity showed no foci of infection, and tonsils had been cleanly enucleated, his sinuses were clear, his other physical examination was quite negative. His symptoms, besides abdominal pains with colics and vomiting, were definitely urinary in type—frequency, nocturia and some pus cells found in the urine. Under prostatic treatment his symptoms promptly cleared up, and with occasionally being examined, he has remained free from all his abdominal symptoms for a period of three years.

Disturbances, or aberration of the sexual functions are more or less common and may range from acceleration to total impotence and sterility. Cunningham reports a number of cases of sterility entirely recovered after open drainage of the seminal vesicles. Mental symptoms may be quite prominent, extending from apprehension, depression, melancholia and despondency. Many of these symptoms elicited in obtaining the history of the patient point to a possibility of urologic infection and should be carefully excluded.

UROLOGIC EXAMINATION

It is this examination that I wish most to emphasize in this paper, as many cases are examined and are pronounced negative, whereas a more careful examination, or one properly made, would have resulted in a positive and proper diagnosis. The first step in the examination should be an examination of the urethra and meatus for a possible urethral discharge. Second, proper examination of the voided urine. Third, examination of the prostate and seminal vesicles per rectum. Fourth, collection and examination of the expressed secretion. Fifth, macroscopic and microscopic examination of the urine. Sixth, macroscopic and microscopic examination of the expressed secretion. Seventh, culture of the secretion. A simple and practical routine for this examination should be followed in each case. The patient should present himself for examination with the bladder full of urine. This is voided and collected into two or three glasses, not more than one ounce in first glass, then about two ounces is collected in the second glass, the remainder being retained, as the prostate is best examined with the bladder quite full. After the examination of the prostate and seminal vesicles, the bladder is emptied into the third glass. The first glass will contain the urethral excretions, and will probably contain shreds, many of these small, comma shaped,

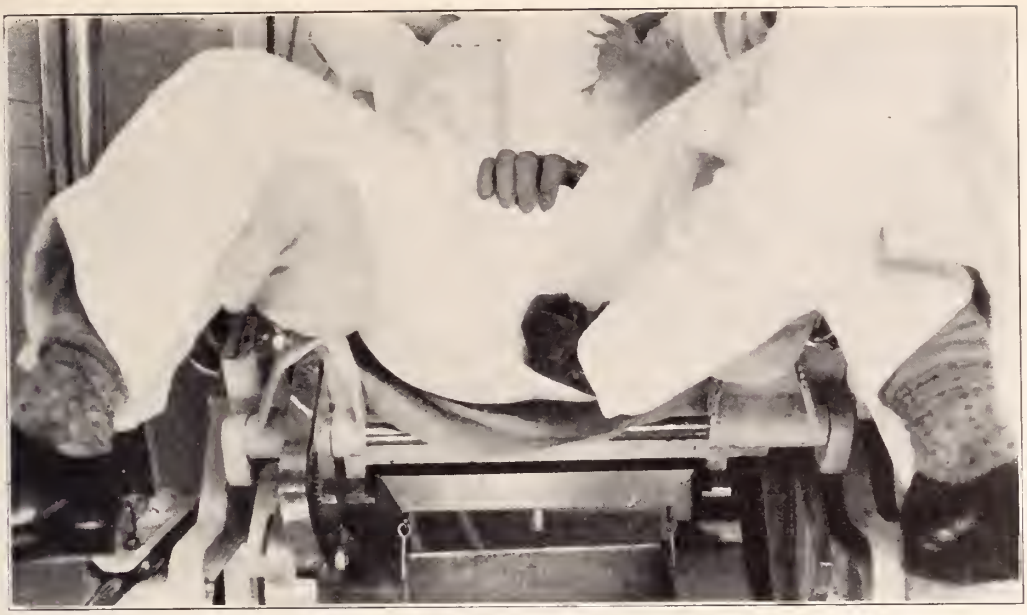

Fig. I, II. Illustrations of most satisfactory position on table for examination of seminal vesicles and prostate.

some larger, it may be quite hazy or at times quite cloudy. If these shreds are found in the first glass, one is very certain that prostatitis exists. The presence of clumps of mucus and shreds do not always mean prostatitis, but the larger shreds do not come from the urethral or Littre glands. If these shreds are found in the second glass, they offer definite evidence of prostatic involvement. In some cases both the first and second glasses will be clear, and that in the third glass, examined after massage, will reveal not only shreds, but pus cells, both singly and in clumps.

EXAMINATION OF THE PROSTATE

As stated before, the prostate is best examined with a full bladder. If it has been emptied it is well to fill the bladder with some solution. There are varying positions for the examination of the prostate. Personally, I do not believe that a prostatic examination

Fig. II.

with the patient leaning across the table is of much value. The knee elbow position gives a very satisfactory examination, likewise the lithotomy position. However, the semi-sitting position, with thighs flexed, gives by far the most satisfactory position for palpating both the prostate and seminal vesicles. (See Figures I and II) With the bladder full, and pressure of the right palm suprapubically the seminal vesicles and prostate can be brought within the reach of the examining finger, even the doctor with a short index finger may make a satisfactory examination in this position. The prostate should be examined as to size, the lobes compared, consistency observed, and determined. The lobes should be defined with ease, and if they cannot, there is certainly pathology present with peri-prostatic infiltration. If there is a marked difference in the size of the lobes, one may infer that there is either congestion on the one hand, or possibly a long standing prostatitis with fibrous changes on the shrunken side, which will be dense and hard in comparison. The examination should take note of areas of induration, hardness, areas of tenderness, equality of the lobes, mobility or adherence, fluctuation, and peri-prostatic and perivesicle thickening. After the prostate has been examined, examination of the vesicles is necessary. It has often been stated that a normal vesicle cannot be palpated. This is essentially false, because proper examination will reveal palpable vesicles in every case, although they vary in size and shape in different individuals. Sargent has shown this beautifully with the vesiculograms that he has collected. During the examination of the vesicles and prostate, they are carefully massaged to secure the secretion for examination. Care should be taken that the massage should not be too vigorous, and that this should be a milking movement from above downward in the vesicles, and from the lateral walls of the prostate inward toward the urethra. Secretion obtained is carefully collected, and the bladder is then emptied into the third glass, or if desired, two glasses and the sediment is carefully noted. Microscopic examination is always made, and cultures may be made if deemed necessary. Microscopic examination is both an examination of the fresh secretion and a stained smear, either by the Gram, methylene blue, or Pappenheim stain to bring out the pus cells. If spermatozoa are present, one feels sure that the seminal vesicles have been emptied. It is well to note here, that a single negative examination is not conclusive, and that one frequently must make one or two very careful examinations before satisfactory diagnostic findings will be obtained, and it is not uncommon that on a second examination, from one that was negative on the first examination, much pus and shreds will be obtained that microscopically and culturally show bacteria. Von Lakum has called attention to this, and in some cases uses a provocative treatment instilling nitrate of silver, or even dilating the urethra before getting results. From this you will see how many cases reported negative on urologic examination would probably be positive if greater care were taken and proper technique used, with proper massage and repeated examination; and that single negative findings are of little or no value where symptoms exist, but the examination must be repeated, before prostatitis and seminal vesiculitis can be excluded.

TREATMENT

The treatment of cases of seminal vesiculitis and prostatitis is essentially one requiring time and patience, not only on the part of the physician, but also on the part of the patient, and because the pathology is so located with poor drainage, there is a tendency to recur, and these patients are oftentimes recurrent patients, coming willingly because of the relief obtained. Treatment of chronic prostatitis and seminal vesiculitis consists of massage at frequent intervals, irrigations of the urethra and bladder, posterior urethral instillations, and urethral applications. Massage may vary from two or three times a week to daily. Intravesicle irrigation with potassium permanganate in strength one five-thousandth to one ten-thousandth (1/5,000 to 1/10,000). Instillation of protargol one-half of one per cent (½of 1%) solutions, instillations of silvol, neo silvol, silver nitrate, mercurochrome, or acriflavine. Cunningham, taking his cue from the gynecologist, has

used instillations of pure glycerine. I have used this in a great many cases, and I am of the opinion that it is of the most benefit of any instillation used. Urethral dilation as an adjunct is important, however, great care must be taken not to cause trauma, and the frequency of treatment and the degree of dilation depends entirely upon the case. Heat has a very distinct value applied either by the sitz bath, rectal irrigation, rectal application of heat, and probably diathermy has a value. Probably the sitz bath has been used with more success than any other form of heat application, although in some cases sitz baths are impracticable and either diathermy or high frequency as an office or hospital procedure are of value, certainly they will increase the office income, and I am afraid in a great many cases that is their only value. Vaccines and foreign proteins have been used and have been quite popular in England. Some urologists think vaccines are quite beneficial. Player, Brown and Mathes report no practical results. Von Lakum has been using aolan combined with local treatment, especially in cases of arthritis. Surgical treatment has been advocated and carried out in a great many cases with extremely good results. Morrissey has reported numerous cases. Cunningham says this was more prevalent a few years after the war than at the present time, but surgical drainage seems the only advisable method where the vesicles are sacculated and where prostatic abscesses are present. Surgical drainage gives a shorter convalescence, and undoubtedly, a more definite recovery than non-surgical treatment. In passing, it is interesting to cite a few cases that were

Fig. III. Seminal vesiculogram, lipiodol injection.

apparently cured by injection of iodized oil to secure vesiculograms.

CASE HISTORY

P. M.—This man, a carpenter, 46 years of age, completely disabled with arthritis of lumbar and dorsal vertebrae. Examination, essentially negative. Has had his teeth extracted, tonsils removed, appendix removed, gall bladder removed, without relief of symptoms. Examination shows definite seminal vesiculitis. (See Fig. III) Vesiculograms showing large sacculated seminal vesicles. Drainage was advised. The patient went home to prepare for hospitalization, but came back in three weeks very much improved. Examination showed seminal vesicles still palpable, but tenderness markedly decreased. Eight weeks after the vesiculograms, patient had returned to work as a carpenter, and followups show that he has continued with no further loss of time. Cultures in this case showed a streptococcus and x-rays of the spine quite marked peri-arthritic changes.

The patient cannot be pronounced cured by alleviation of symptoms, but clinical observation is as important as laboratory tests, and after both cultural and microscopic tests are negative a recurrence of symptoms and light up of processes may occur. Urethroscopic examination is very important to pronounce a cure. It may be stated that if there are no clinical symptoms, if microscopic tests show no pus in secretions, cultures are negative, prostate and seminal vesicles appear normal on digital examination, and urethroscopic shows urethra, verumontanum, and the ejaculatory ducts free from redness and irritation, the patient may be discharged as cured.

CONCLUSION

Seminal vesiculitis and prostatitis is a common disease of adult males. Thirty-five per cent of all males have prostatitis and seminal vesiculitis. Sixty per cent of these give a history of gonococcal infection. Many cases undeniably are directly attributable to foci of infection of teeth and tonsils. Chronicity of prostatic infection is due to poor drainage, and cure depends upon the establishment of good drainage, either by prostatic massage, or surgical drainage. Success in diagnosis and treatment of seminal vesiculitis and prostatitis depends upon proper technique of examination, and treatment. It is necessary for the general practitioner, the orthopedist, the internist, the surgeon and the urologist to make a careful rectal and urine examination to diagnose or exclude existing prostatitis or seminal vesiculitis.

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Tuberculosis, Rickets, and the Diet

By G. J. HILDEBRAND, M. D.
Sheboygan

The importance of fats in the dietary management of pulmonary tuberculosis has long been known. Empirically, for many years much stress has been placed on a fat-rich diet and on preparations rich in fat, like cod liver oil.

The therapeutic action of Chaulmoogra oil in leprosy, known for many years, was probably the fact that brought about experimental investigations regarding the action of fats and lipoids in tuberculosis.

Jacquerod (1) states: "The absorption of fatty bodies allows the latter to arrive directly in contact with the pulmonary tissues before any assimilation or utilization by the rest of the organism has taken place. Peptone and the carbohydrates are absorbed by the veins and modified by their passage through the liver before entering the general circulation. Fats, on the contrary, are absorbed by the lymphatics in the form of a milky emulsion, which by the intermediary of the thoracic duct, is thrown into the right heart and from here directly into the lungs. Hence the aim of treatment should be to cause the circulating fat to pass into the lungs as abundantly as possible."

Platanov (2) calls attention to the necessity of fats in nutrition. During the World War, tuberculosis spread because of diminished resistence of the body, as brought about by hunger and especially by insufficiency of fats. He points out the decrease of unsaturated fatty acids in organs of the tuberculous and underfed. Insusceptibility of some animals as the horse to tuberculosis, the high susceptibility of the guinea pig, the different degrees of susceptibility of various organs in one and the same organism may be explained by peculiarities of chemical composition of the infected organism or organ. Some fats as cod liver oil retard the growth of the tubercle bacillus. Oleum hydnocarpum possesses strong bactericidal action, also cholesterol and lecithin. These various facts suggested to him the possibility of applying unsaturated lipoids in the dietary treatment of tuberculosis. Tubercle bacilli do not grow readily in organs rich in fat and so we rarely find tuberculous lesions in the meninges and suprarenals, as these organs are extremely rich in unsaturated fatty acids. He also explains the immunity of the horse to tuberculosis by the presence of certain unsaturated fatty acids in horse serum.

The use of fats or fatty acids in tuberculosis has been suggested by a number of other workers in tuberculosis. E. Wolf (3) treated twenty-eight patients, all in the chronic tertiary stage with a non-specific lipoid preparation, given parenterally. Treatment extended over a period of three to four months. Thirteen patients were cured, fourteen improved and one was not influenced. Wolf says that in addition to their important roll in both specific and nonspecific immunity in tuberculosis, lipoid bodies bind toxins, destroy bacteria, stimulate fermentative processes, favor deposition of protein and increase blood lipoid.

That disturbed metabolism of cholesterol, a fat-like substance, may play a part in tuberculosis, has been suggested. Cholesterol is present in the blood and in most animal cells. It is found especially in bile, but not much is known concerning the role it plays in body metabolism. In acute tuberculosis, the blood cholesterol is low, while the greater the resistance of the patient to tuberculosis, the greater the cholesterol content of the blood. Hypercholesteremia in pulmonary tuberculosis is therefore of good prognostic import. Cholesterol or cholesterolesters accumulate in tuberculous tissues and especially in the actual anatomic tubercles.

Much has been written about the absence of tuberculosis amongst various people. Certain tribes of African natives are said to be

free from tuberculosis. While the American Indian did have some tuberculosis, it was comparatively rare until after the advent of the white man. This freedom from tuberculosis has usually been attributed to the isolation of these people. When tuberculosis did develop it was usually rapidly fatal, supposedly because of the virgin soil. The main source of food supply of the Indian was of animal origin. Hunting was their chief occupation, and often after special killings, the people would feast and gorge themselves until hardly able to move. Fats were always considered a delicacy. Those of you who have read Theodore Roosevelt's work about his hunting trips into Africa will know that the African native is much the same in this respect. The diet, the absence of crowded conditions, the life in the open, and exposure to air and sunshine may be factors which made tuberculosis a rare occurrence. When infection did occur it often no doubt was brought about by overwhelming doses because of the total lack of hygiene. Whether these people would be able to cope with small or moderate doses of tubercle bacilli is a question, but there is reason to believe that they have a certain amount of resistance and that the absence of tuberculosis is not entirely due to their isolation and lack of infection.

The Indian has always been isolated to a certain extent from the rest of the population, and the fact that tuberculosis became rampant amongst the Indians after the advent of the white man, was probably due to a much lowered resistance caused by a marked change in their diet and mode of life. The African negro in his native state is comparatively free from tuberculosis. Let him dwell among civilized people, change his diet and mode of life, and as a consequence tuberculosis will rank first as the cause of death.

The high resistance of the Jewish race to tuberculosis is attributed to the tuberculization of the race (4). Attention is called to the fact that for over 2000 years political custom compelled them to live in over crowded ghettos under adverse hygienic conditions. Thus the Jews have always been exposed to tubercle bacilli, and have gradually developed a high degree of immunity. Acute forms of tuberculosis are rarely seen among Jews, and their mortality rates are about one-third lower than those of other races among whom they dwell. But with these people too, I may point to the diet and ask what, if any, effect has this on the incidence of tuberculosis? Jews are fond of greasy foods; fish forms an important item in the diet.

RICKETS AND TUBERCULOSIS

Where the incidence of rickets is high we also find that the incidence of tuberculosis is high. In European countries, during the late war and post war period, the rise in the number of cases of tuberculosis and rickets was marked, only to drop again as conditions, especially the food supply, improved. Rickets and tuberculosis are both very prevalent in the American Indian and the negroes of this country. Among other peoples as the Jews for example, who have a high resistance to tuberculosis, rickets is less prevalent than among the ordinary population.

I have mentioned the relationship of fats in the diet to tuberculosis. That other factors than the lack of Vitamin D are concerned in the etiology of rickets, has been suggested by Weston (5). He says, "Proteins and fats of animal origin appear to be important factors in the etiology of rickets because it has been repeatedly observed that, where the food supply is preponderantly of animal origin, rickets is rare or non existent." He quotes McCollum who asserts that "Wherever meat and dairy products constitute the larger proportion of the diet, the physical development of the people is excellent, but when agriculture thrives in growing cereal grains and tubers as the most profitable form of produce, physical deterioration as shown by stunted growth, physical inferiority, and defective and carious teeth is likely to characterize the people of both the rural districts and the cities." To quote Weston further, "It is a matter of common observation among those who are familiar with the plantation life of the negroes in the southern section of the United States, that they spend most of their time out doors, both young and old, and that they wear few clothes, the babies and children often none. Yet rickets is common among the infants

although they are breast fed. The mother's diet consists mostly of corn bread, white flour bread, a gruel from corn meal, bacon and vegetables boiled with bacon."

In contrast to this he quotes Mellanky who described the living conditions on the island of Lewis. The inhabitants there live under the worst hygienic conditions imaginable; many of the houses have a filthy byre in one end of the building and most of the houses do not contain a window. A peat fire is kept constantly burning, the smoke of which can escape only through the thatched roof or the open door. The babies are taken out only in the bright weather which is not often; but, he says, "Regardless of these unhygienic conditions the children remain actively free from rickets. The babies are invariably breast fed and the mother's diet consists of cod heads stuffed with cod livers, milk, fish, turnip, oatmeal and potatoes. The chief element of the diet is of animal origin."

To speak further on the relationship of rickets to tuberculosis, let me cite the experimental work of Grant. Grant (6) and her co-workers showed that white rats, ordinarily highly resistant to tuberculosis, could be made susceptible to this disease after the animal had been made rachitic by feeding a ration defective in calcium and Vitamin D. These investigators fed young rats on rations presumably adequate with the exception of calcium and the antirachitic factor. Rickets regularly appeared more readily in cloudy weather than in bright. In the group of these animals, injected with tuberculosis organisms, the disease could be demonstrated not only by microscopic study of the tissues, but also by transmitting it to guinea pigs. The series given the defective ration alone, developed rickets but no tuberculosis, while doses of the infecting organisms, many times larger than those used in the rachitic group, failed to induce tuberculous lesions in a number of rats given an adequate ration. Whether rickets in childhood may cause some permanent deleterious disturbance in the calcium metabolism which would make an individual more susceptible to tuberculosis later in life forms an interesting speculation. In this connection it might be well to call attention to a well established fact—that is, that chicken breasted individuals are especially prone to develop tuberculosis.

VIOSTEROL IN TUBERCULOSIS

And now come the interesting announcements from various workers in the field of tuberculosis on the favorable action of viosterol in cases of pulmonary tuberculosis. Because of the fact that forms of pulmonary tuberculosis show a marked tendency to spontaneous calcification, Levaditi and Le Yuan Po (7) proposed to find whether such calcification takes place because the lesion tends toward cicatrization, or whether the tubercles heal because the organism acquires the faculty of surrounding them with a calcium shell capable of impeding the spread of the bacilli. They also sought to determine whether this tendency to calcification can be considerably increased by giving nontoxic doses of viosterol to tuberculous animals. The result of their experiments gave the following conclusions: 1. The viosterol administered, augments, to a considerable extent, the calcification of the lesions. 2. The calcification of the tubercles is the result of a change in the calcium metabolism. 3. The calcium deposits in the necrosed and caseous tuberculous foci results from the confluence of intracellular calcium concretions. 4. It is probable that the formation of such a calcium shell impedes the spread of infection to surrounding tissue.

H. Menschel (8) makes a report on the value of viosterol in the treatment of pulmonary tuberculosis. He says viosterol checks the exudative processes and favors the development of connective tissue and scar formation around the focus. The clinical symptoms improved in the corresponding manner. Night sweats were checked, fever reduced and the metabolism favorably affected. Many patients recover sufficiently to be able to return to work. Several others have reported similar results.

Much literature has appeared recently on the Hermansdorfer Sauerbruch dietary treatment of tuberculosis. The essential features of this diet are that all food served is salt free, it has a relatively high fat and a low carbohydrate ratio, and supplies ade-

quate amounts of mineral and vitamins. Reports of results by this method of treatment vary. Some authors believe that the treatment has not much value, while others, however, have been favorably impressed and have reported excellent results. It is difficult to say which feature of the diet is the most essential; perhaps they are equally important. However, from what has been previously stated, it perhaps is the increased fat content and the abundance of vitamins which exerts a favorable influence.

Rickets and tuberculosis are either found frequently among certain peoples, or if one disease is rare, then we find that the other is also rare. Cod liver oil, viosterol, and sunlight are specific for rickets; they are also useful in tuberculosis. It has been suggested that fats and proteins of animal origin are necessary besides vitamin D for the prevention of rickets. Fats are also advocated in the dietary treatment of tuberculosis.

Cholesterol is present in most animal cells. Cholesterol, when irradiated with the rays of an ultra-violet light, acts as an antirachitic agent similar to irradiated ergosterol. It is, however, not such a strong antirachitic agent as irradiated ergosterol but is said to have greater bactericidal action. I have previously mentioned that hypercholesteremia is of good prognostic import in tuberculosis. Cod liver oil contains slightly less than one percent cholesterol.

For some time it has been advocated that people restrict the amount of protein in the diet and partake of larger quantities of vegetables. It may, however, be better for the physical welfare of the people that proteins and fats of animal origin be given their proper importance in the diet and that all people eat sufficient quantities of these foods at least until they reach the age of thirty-five years. At about this age most people put on fat more easily and it would then be permissible to decrease the foods of animal origin and correspondingly increase the vegetable foods. Parenthetically, it might be stated that comparatively few cases of tuberculosis develop after the age of thirty-five. Whether the ease with which the body at about this age puts on fat, makes the organism more resistant to tuberculosis, is an interesting theory. Those cases that we do see in people past middle life are usually of the chronic fibroid type often producing but slight symptoms, indicating a high resistance to the disease.

During the past twenty years there has been a marked decline in tuberculosis and in the campaign against this disease the importance of proper food has been stressed. This has resulted in a marked increase in the consumption of dairy products. Milk now forms an important part of the diet, especially for the growing child.

Has this increased use of foods of animal origin been one of the factors that has brought about the remarkable decline in the incidence of tuberculosis?

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EPIDEMIOLOGIST WANTED

The city of Milwaukee will hold an examination late in June for the position of city epidemiologist left vacant by the resignation of Dr. Merle French. Applications should be made at once to Mr. H. W. Cornell, secretary, City Service Commission, 7th floor, City Hall, Milwaukee, Wis.

Behavior Problems in Children*

By M. G. PETERMAN, M. D.
Milwaukee

The behavior problems of childhood are not a recent development nor is their satisfactory treatment a recent innovation in medicine. It is true that the modern trends of civilization which have brought with them later marriages, smaller families, and much less home life or time spent by parents with their children, have created new problems and have increased the number of behavior disturbances many times. However, the pediatrists and the general practitioners who treat children have not been oblivious to this changing situation. The medical profession, more especially the pediatrists, cannot be accused of neglecting or ignoring the psychology of childhood, normal or abnormal. For many years the competent family physician has corrected the problems of tantrums, anorexia, masturbation, negativism, hysteria, truancy, etc. For the most part his treatment has consisted in changing environment, providing new outlets, and in intelligent neglect, all of which form a large part of the armamentarium of the behavior specialist today. A number of individuals have been critical of the general practitioner and the pediatrist, accusing them of indifference and failure to keep up with the recent developments in child psychology. This accusation is perhaps true only in so far as the new terminology is concerned. New terms have been found to designate symptoms and conditions which have long been common knowledge. The greatest contributions to the study of child psychology have been made by general physicians and pediatrists and a few psychiatrists. Simon, Binet, Terman, (Standards for estimating intelligence levels), Czerny (*Der Arzt als Erzieher des Kindes*), Cameron (*The Nervous Child*), and William A. White (*The Mental Hygiene of Childhood*). Among recent contributions the outstanding are the studies of Krasnagorski and his school on the conditioned reflexes in normal and in abnormal states.

There has been a change in the attitude of pediatrists toward behavior problems since the time of Holt. In 1922 this leader of pediatric thought stated that, "Most of the neuroses of childhood depend entirely upon disorders of nutrition. The headaches, insomnia, disturbed sleep, chorea, habit spasms, hysterical manifestations, and a multitude of others are relieved only by correcting the faulty diet and habits which are the basis of the disturbed nutrition." We know today that malnutrition is only a factor in some of the neuroses. As many cases of malnutrition depend upon behavior states as vice versa—for instance "anorexia nervosa." Inadequate nutrition, like fatigue, is only one of the factors in the multiple causations of the behavior changes.

Olson states "Since the ponderal index is not only a reflection of nutritional status but also of body build, there is the possibility that the increased nervous habits at the extremes are, in part, symptoms of maladjustment. The writer has shown elsewhere that children who are at the two extremes of such traits as strength, energy output, and susceptibility to fatigue become behavior problems in the public school in larger measure than those at the average." Here again sociologic study might establish a clearer relation between cause and effect. The findings do not prove that nutrition is the basis of the problem. Helen E. Woolley found that "Whether or not a given family or school situation proved to have a disturbing and inhibitory effect on the child's progress depended very largely on the disposition of the child."

Wile has stated clearly the attitude which most pediatrists accept today: "The behavior difficulties of children are, therefore, symptomatic of disharmonies that arise primarily within their own bodies or as a result of thwarting factors in their environments. The sweep and urge, the intensity and duration of emotional stimuli are of profound importance and of greater influence than the intellectual status of children in determining

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the nature of their behavior patterns. The internal life of the child has been overstressed. Even the Adlerian doctrine of constitutional inferiority fails to give full credit to the force of social pressure and regulation upon behavior trends. If the influence of heredity and environment are equal, one must assume,—indeed, one knows it to be true—that the inherited potentials are modifiable by social culture. For many years interest in the physical welfare of children has led to an overstressing of physical handicaps as causes of misbehavior. It is true that in a certain proportion of children the physical state contributes to a sense of inferiority, which is overcompensated for by anti-social activities. Speaking in general terms, however, the behavior problem, slight or serious, cannot be catalogued under specific forms of physical deficiencies."

TWO GROUPS

The behavior problems of childhood may be divided into two large groups. The functional disturbances which include most cases of anorexia; temper spasms or tantrums; enuresis (when there is no pathologic lesion in the genitourinary tract); habit tics; masturbation; delinquency. Those problems which arise on an organic basis include cerebral palsies and the residues of birth injuries; chronic encephalitis and encephalitis residues; chorea residues; Mongolian idiocy; congenital mental deficiencies. In a study of the child, the first step, then, is an effort to place his case into one of these two groups. This may often be done on the basis of a careful history. Time only should limit the extent of detail in a pediatric anamnesis. It is of the greatest value to begin with a study of the parents and their states of mental and physical health, their reactions toward each other, the family economic situation, the number of children, their ages and state of health; the history should follow with as much information as possible concerning the condition of the mother during her pregnancy. Here then we have the background into which the patient is introduced. Now the birth history, duration of labor, type of presentation, use or abuse of instruments, methods of resuscitation if any, and the condition of the infant are of importance. Next we trace the development of the infant, his disposition, tendency to colic, the time of sitting alone, walking, talking, recognizing objects and so forth, as far as time or the parents' memory will permit. Thus we may study the foundation of the child's physical development and character. The infectious and other diseases of childhood follow, giving us information as to exposure, susceptibility, power of recovery, etc.

We are now prepared for the chief complaint and with usually a fair idea of its relationship, if any, to some preceding disturbance. I believe that almost half of our behavior problems develop on the basis of some organic lesion; hence, the importance of a detailed history. Even then, information may be lacking or incorrect as to birth trauma, cyanosis, convulsions, or the initial encephalitis lesion. A great many of the patients we see presented with complaints of mental retardation, irritability, nervousness, and delinquency are suffering from the residues of cerebral hemorrhage or injury at birth. Hamill has said that, "The child of violent temper who later grows up as an incorrigible, a recidivist, or a moral pervert may owe his anti-social mentality to some small brain destruction in infancy," G. B. Smith has made a study of 50 children who had had birth trauma. Of these, 22 per cent became normal, 16 per cent were morons, 40 per cent imbeciles, and 22 per cent idiots. The anti-social tendencies were greatest among the group with the least mental retardation, behavior being characterized by irritability and lack of concentration.

Encephalitis residues, or chronic encephalitis, probably follow cerebral birth injury in importance among the causes of behavior problems with organic basis. The original encephalitis may be the epidemic or lethargic form, or it may be a complication of one of the acute infectious diseases, such as scarlatina. The sequel, chronic encephalitis or encephalitis residue, presents the most difficult behavior problems we have today. Whether the residue takes the form of a respiratory, Parkinsonian, reversed sleep, epileptoid, or other syndrome, there is usually a marked behavior disturbance. This consists

in part of extreme motor activity, purposeful but not consistent; failure to concentrate; absence of judgment; etc. Treatment seems of little avail and we have no provisions for institutional care.

Further, I have now seen a number of patients with behavior disturbances, some with convulsions, in which a careful history has failed to reveal an adequate basis for an organic lesion.. Encephalography has demonstrated areas of cortical atrophy. The cause is unknown.

I shall not enter into a discussion of the treatment of these behavior problems which have an organic basis. They require a great deal of combined effort on the part of the pediatrist, orthopedist, physiotherapist, and teacher. The pediatrist must learn, however, to distinguish between the behavior disorders which arise on an organic basis and those which are the product of unhealthy or abnormal environment. This ability depends upon an understanding of the normal child and his psychology. To quote White, "Unfortunately the great discrepancies between the child world and the adult world too often serve to make the child mysterious and so to deepen the gulf between it and the adult. This lack of understanding is at the bottom of much bad hygiene, not to say cruelty, and it is the rule largely because, as adults, we remember practically nothing of our early years, only isolated instances of little importance and clothed in the imagery and understanding of later years."

Lowrey reminds us that, "We must recognize that the child is constantly experimenting with the whole environment, physical and dynamic, by the use of varying modes of behavior, innate or acquired, to find situations in which the behavior is successful or in some way satisfying. This is the explanation of the frequently repeated point that all children, at some time in their career, lie, run away from home, steal, have temper tantrums, refuse food, etc. Whether or not the behavior will continue depends upon a complex of interacting factors, the chief ones lying in the attitude of the adults and the satisfactions achieved by the child." To understand the functional behavior problems it is essential to determine the cause. When the basis of the disturbance is understood, the treatment suggests itself; namely, a readjustment or a change in the environment.

PRACTICAL TREATMENT

In the practical treatment of the problems of enuresis, tics, temper tantrums, anorexia, I have found hospitalization in a children's hospital the most effective procedure. Here one may have the opportunity of observation without the presence of relatives and thus in a few days one can gain most intimate contact with his patient. A definite daily schedule must be arranged with adequate provision for mental and physical energy outlets. So far as the patient is aware, the physicians and nurses utterly disregard or make very light of the presenting complaint. Food is served at regular intervals in an attractive manner but all ostensibly part of the general routine. Wards are preferable and the atmosphere is one of happy, friendly competition in games and tasks. If the response is not satisfactory, subtle suggestions are made and the results are made common knowledge in the ward but only in an offhand way. The child is placed much on his own responsibility, whereby he soon loses his ego, develops new aims, and forgets his vicious or unsocial tendencies. During this period the parents are given instruction and books to read. When possible, the child is returned to his home through an intermediary step. He is discharged into the home of a relative. The results even in some organic diseases as asthma, epilepsy, and chronic encephalitis have been very encouraging.

For pure research into the psychology and psychopathology of childhood, I believe that the studies of Krasnagorski and his pupils will yield the greatest results. The great pediatrist Czerny suggested that physiological methods offer the means for a study of the higher nervous activity in children. Burnham and Mateer in this country are carrying on this type of experimental investigation. The fundamental nervous phenomena which has been used to open the field of physiological investigation of the brain is the conditional reflex of Pavlov. "Conditional reflexes are reactions, which are temporary, acquired in life, individual and vari-

able according to external conditions; in these properties they differ from unconditioned reflexes, which are permanent, innate reactions, belonging to the species, appearing in all conditions." The methods in detail and in technic are described in Krasnagorski's publications. May I superficially present some of his observations? The fundamental function of inhibition consists in developing innumerable inhibitory effects to both conditioned and unconditioned activities. These inhibitory reactions have all the characteristics of conditional reflexes. All the most subtle differentiations, extinguishing and delaying of conditional reflexes are based on the development of the cortical inhibition. It was proved that every sudden change of excitability in the cell does not remain isolated but involves surrounding cells, spreading sometimes over large fields of the cerebral hemispheres with a certain speed along certain pathways. Concentration manifests itself in the fact that the excitation of some cells produces inhibition in others. In a normal nervous system, irradiated inhibition is immediately replaced by an energetic concentration and induction, in pathological cases the spread inhibition very often becomes stable and acquires a character of a statical process. The cerebral cortex consists of innumerable conditional reflex systems, some of which develop positive and other inhibitory effects. The cortex systems are of a temporary character constantly changing in their structure depending upon the influence of surrounding conditions. The activity of the cortical systems is dynamically strictly coordinated with that of the subcortical regions. Every change in distribution of excitations in subcortical parts immediately influences the function of the corresponding cortical systems. We have received the most powerful and regular conditional responses when the subcortical excitability was optimal, for instance, in a healthy appetite.

In other experiments we have decreased the excitability of the food center by previous satiation,—under these conditions, the magnitude of the cortical reflexes diminished and sometimes disappeared entirely. The decrease of excitability in the subcortical centers deprived the cells of the cortex of that excitability which was necessary for the realization of the conditioned reflexes. In a series of observations we decreased the excitability in some parts of the food center and augmented it in others by means of a prolonged, one-sided nourishment and investigated under these conditions the magnitude of the conditioned reflexes, which has been established on the different components of the food. The experiments of Drs. A. A. Jouschenks and A. I. Machtinger have shown that the conditioned reactions fell on those components of food with which the child had been overfed, so, for instance, over feeding with carbohydrates diminished the conditional carbohydrate reflexes; overfeeding with salts diminished the salt reflexes, etc.; at the same time other conditional reflexes remained without change. Besides the decrease of conditional reflexes, the unconditional secretion also diminished . . . The second phase, which we call the leveling excitatory phase, comprises the cases where reactions are very great and do not follow the law of force; the weak and strong stimuli produce equally strong effects. This state represents undoubtedly a pathological condition, forming a physiological basis for some neuroses, e. g., neurasthenia.

. . . . The paradoxical way of reacting is an indication of weakness of the cerebral cells and is often observed in infants and in hysterical patients. In pathological children there develops still another ultra-paradoxical phase, when positive conditioned stimuli produce the inhibitory effects and the inhibitory stimuli the positive conditioned responses . . . The most profound disorders of the conditioned reflex activity were revealed in different stages of idiocy. In severe forms, the cortical functions were so weakened that the establishing of conditional reflexes was entirely impossible (U. K. Panferov). These individuals were unable to develop even the most elementary reactions of adaptation. In lighter forms of idiocy, the conditioned reflexes could be established but they differed from normal conditioned responses in regard to specificness, extinguishing, stability, and sensitiveness to external agents.

The tendency to wide generalization of the conditioned reactions and a great enfeeble-

ment of the process of concentration are the characteristic features of the highest nervous activity in idocy . . . In severe neglected forms of myxedema we could find the same characteristic changes as in inborn idiocy. (N. R. Shastin) . . . Thyroidine influenced favorably the inhibition process; after several months, it became possible to establish differentiations and conditioned inhibitions instead of the reflexes of the second and third orders.

In normal children we have soon found that every conditioned reflex both positive and negative may be made functionally diseased by means of fatigue or conflict with strong excitation or inhibition. An ill reflex has a certain pathological influence on adjacent reflexes; a temporary pathological area, as it were, a functional ulcer is formed around it. Between this area and the surrounding cortex new pathological dynamic interrelations are established. Every touch to this "ulcer" produces a pathological irradiation of excitation or inhibition and also pathological inductions in the surrounding parts and in this way the pathological focus immediately influences the whole activity of the cerebral hemispheres. There develops a temporary, local neurosis. In healthy, strong nervous systems, these functional disorders are quickly healed; the strong nervous cells quickly restore their optimal excitability and a normal equilibrium between excitation and inhibition. In children with constitutionally deficient cortex the weak cells are unable to restore their normal excitability speedily and therefore the pathological foci may remain in the cerebrum for a long time.

CONCLUSION

The important question confronting us in behavior problems of children, especially of younger children, is the presence of an organic lesion. The existence or even suggestion of a definite lesion decidedly alters the treatment and prognosis of a behavior disturbance. The percentage of organic lesions depends entirely upon the source of the material. Newer diagnostic measures will reveal an increasing number.

THE JOURNAL CLINIC

Dislocation of the Foot From the Astragalus; Report of Case

By C. KENNETH COOK, M. D.
Jackson Clinic, Madison

A man, aged 29, came to the Jackson Clinic, July 7, 1930, with a very unusual condition. He had fallen from a load of hay when it tipped over and had sustained an injury to the left ankle. He complained of severe pain in the ankle on admission and physical examination showed the left foot inverted about 75 degrees from normal. It was noticed, however, that both malleoli were apparently in their normal positions. From this examination and the unusual prominences on the dorsal aspect of the foot, it was apparent that there was something more than an ordinary dislocation of the ankle.

Roentgenograms revealed the following conditions, "the unusual medial dislocation of the entire foot at the astragalus calcaneal tarsal articulation with a chip 1 by 1½ cm. fractured from the posterior aspect of the astragalus and a fragment 1 by 2 cm. from the posterior medial posterior superior aspect of the tarsal scaphoid."

The prominences noted previously were found after roentgen-ray examination to be the tarsal scaphoid displaced upward from its articulation with the astragalus and the anterior portion of the os calcis which was displaced upward somewhat from its articulation with the tarsal cuboid. Both of these prominences were just subcutaneous and the skin was drawn tightly over them and blanched in appearance. In reality this case consisted of a dislocation of the articular surfaces of the astragalo-scaphoid joint, the scaphoid being displaced dorsally. A dislocation of the astragalo-calcaneal articulation

Fig. I. Medial dislocation of foot from astragalus.

with the os calcis was displaced medially and to the plantar surface, and a partial dislocation of the cuboid toward the plantar surface and medially. All of these resulted in a marked inversion of the foot from the astragalus.

A spinal anesthesia was given and the dislocation easily corrected by slight extension

Fig. II. Lateral view.

on the foot. A plaster cast was applied and after 10 days the patient allowed to go home on crutches. At the end of six weeks the cast was removed and physical therapy started. At the end of ten weeks the patient walked without crutches, twelve weeks from the injury he was fully recovered without disability, but still complained of some weakness in the foot.

I have reported this case because of the unusual nature of the injury—the astragalus maintained its normal relation to the tibia and fibula but the foot was dislocated medially from the astragalus and the two chip fractures. I have been unable to locate a similar case in the literature.

Pseudo-Hermaphroditism; Case Report*

By GERALD K. WOOLL, M. D.
Janesville

This paper is presented as a plea for more careful diagnoses of congenital defects of the external genitalia rather than as a treatise on the surgical treatment of such anomalies.

There is probably no other group of organs in the human body where congenital defects occur more frequently than in the genito-urinary apparatus; therefore, a brief discussion on that deformity of the genitals which consist of the persistence of the male and female organs in the same individual—the so-called hermaphrodite—should be of some interest to us.

Without burdening you with a long detailed review of the embryological develop-

* Presented before North Central Branch, American Urological Association, Indianapolis, Nov., 1930. Dr. Wooll died on March 16, 1931.

ment of the genito-urinary tract, may I recall a few facts which may make the genesis of such defects easier to understand:

1. Every embryo possesses Wolffian ducts and Mullerian fibers.
2. The foetal disposition of genital ducts is bisexual.
3. The germ glands, whose development is rather stationary in early foetal life, may later progress in two directions.

Pathology recognizes two types of this condition, namely, True Hermaphroditism, and False or Pseudo-hermaphroditism. The former being applied when both male and female glands exist side by side in the same individual; and the latter when the construction of the genital glands are of one type and the external genitalia are of the opposite type.

True Hermaphroditism, that is, when one side has the male germinal gland (the testicles), and the other side the ovary, is very rare. The existence of this condition has frequently been denied by many authorities on the subject, but the research work of Von Salen, Garre, Lukomsky, and others has definitely proven that such cases exist. The following brief description is of one of Lukomsky's cases: "Patient, thirty years of age, had a penis two inches long without a urethra, below which was a scrotum with two testes; below the scrotum was a normal vulva, with labia majoris, minora, and clitoris, beneath which was discovered the urethral opening. The vagina was about three inches in length with a normal uterus and cervix. The patient had never menstruated. In having coitus with a female a whitish fluid was ejaculated through the vaginal slit."

Since true hermaphroditism is so rare and its study of only theoretical value, let us consider the other type, pseudo-hermaphroditism, which is much more frequently observed; one investigator (Neugebauer) reporting forty-three cases in his own practice.

The old classification of Klebs, which follows, probably gives one the clearest conception of these cases. Klebs divides pseudo-hermaphroditism in two main groups, each group with three divisions as follows:

I. Female Pseudo-hermaphrodites

A. *Internal*

Genitals are normally feminine in development. Beside the ovaries and more or less perfectly developed ducts, Wolffian ducts may also be more or less developed (this is the rarest form).

B. *External*

The clitoris resembles a penis; the more or less developed labia pudenda resembles an empty scrotum, and in one or both halves small rounded bodies appear, which may be either ectopic ovaries, a hydrocele, a hematocele, or hernia.

C. *Complete*

External genitals are more like the male, beside the ovaries one finds more or less developed Mullerian fibers and Wolffian ducts.

II. Male Pseudo-hermaphrodites

A. *Internal* (more frequent than feminine form)

The external genitals are normally masculine. In the pelvis, however, beside normal or rudimentary formed Wolffian ducts and their derivatives, there is found Mullerian fibers more or less developed (that is, uterus, tubes, and vagina).

B. *External* (most frequent form of Pseudo)

The vulvae imitated by peni-scrotal hypospadias, with more or less rudimentary development of the hypospadias penis. The scrotum may be partly split or completely so. The internal organs are completely masculine.

C. *Complete*

Beside the seemingly feminine external genitals there are to be found more or less developed Mullerian fibers, together with the presence, beside the testicles, of more or less developed Wolffian ducts, for example, uterus with tubes and ligaments, a vagina which often empties into the urethra, or in common with the urethra into the sinus urogenitalis, which is persistent, or else the urethra empties into the vagina.

CASE REPORT

The following is an example of pseudo-hermaphroditism which came under our observation and clearly demonstrates the result of a faulty diagnosis of the condition with its result on the life of the unfortunate individual.

Laura W., age forty-nine, entered the surgical service of the hospital August 14, 1928.

Past History: As long as patient can remember she has had a left inguinal hernia. Patient claims she is a hermaphrodite, and so has never consulted a physician concerning the hernia, because of her reluctance to reveal her genital defect. She has been living on a farm with a brother miles away from her birthplace where people with whom she comes in contact are unaware of her sexual deformity.

Present History: On August 14, 1928, the truss which she had worn for several years slipped out of place while she was visiting some neighbors, and as she was unable to replace the truss it was necessary for her to return home. On arrival at her home she was unable to reduce the hernia, and after several hours of suffering she was finally persuaded to call a physician who referred her to the Clinic for surgery.

Physical Examination: Patient weighed one hundred seventy pounds and was sixty-eight inches tall. The voice was a rich contralto, the hair grey, fine and silky and reached to the waist line; skin of face was smooth and not bearded; the extremities resembled those of a male, being devoid of the usual female adipose tissue, the shoulders were broad and the hips narrow, there were no breasts; the abdomen was negative. Pelvic region showed sparse pubic hair extending toward the umbilicus as in the male. There was a penis two inches long without a urethra, but having a distinct sulcus in its stead lined with mucous membrane. Below and lateral to this rudimentary penis were two bodies resembling labia, the one on the left was considerably larger than the right and contained an irreducable hernia, the right contained a reducable hernia and a testicle a centimeter in diameter which descended with the hernia from the inguinal canal. Between these labial bodies and continuous with the urethral sulcus of the penis was a depression four centimeters long and one centimeter deep into which the urethra emptied. Rectal examination revealed a normal prostate (this patient has legs and feet of a male).

At the operation, both herniae were repaired and two infantile testicles were removed, the second testicle was found embedded in the abdominal wall on the left side. An examination of the pelvis through the operative field revealed no evidence of female organs. No attempt was made to repair the external organs.

To recapitulate: Here then was a male with a peni-scrotal hypospadias and undescended testicles who has been forced to assume the role of a female for forty-nine years due to an improper diagnosis early in life, and who might at least have been saved the tragedy of leaving friends and relatives had the family doctor taken the pains to make a thorough examination, to say nothing about the possibility of a normal sexual life if some plastic work had been done at an early age.

At this late day it would have been an added tragedy to this individual to have attempted to repair the defect, for it would have meant that this individual would have had to assume male attire and thus change his entire social life. The patient was not informed of his sexual condition.

CONCLUSION

Serious error in the education and social life of the hermaphrodite and pseudo-hermaphrodite may be avoided if:

1. Each case is very carefully examined for presence of testicles, accessory testicles, and spermatic ducts, for in the most frequent type, the male pseudo-hermaphrodite, the female appearance is often imitated by peni-scrotal hypospadias.
2. Where one is not absolutely certain of the sex, it is advisable to withhold an opinion until later, demanding a future examination, and finally even to postpone the decision until the individual has attained the age of puberty.

Mediastinal Lymphosarcoma; Clinical and Pathological Observations in a Case

By CHAS. F. ULRICH, M. D.
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and
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Lymphosarcoma, particularly the small, round-celled variety, while rare, is perhaps one of the most common malignant growths occurring in the mediastinum. The benign group of tumors are likewise quite rare and their varieties small. The clinical recognition of tumors of the mediastinum is, indeed, difficult. This is due in part to their rarity and to the fact that the symptoms to which they give rise are exhibited in the more common thoracic diseases. According to Norris and Landis[1], the progress of the disease may be exceedingly rapid or it may be relatively slow. In our case the symptoms extended over a period of not more than nine weeks. A tentative diagnosis of pulmonary malignancy was made ultimately and was corroborated in part by the anatomical findings recorded below.

We are indebted to Dr. I. E. Bowing, roentgenologist, who kindly consented to make repeated x-ray studies of this patient, without pecuniary reward. The interpretation of the accompanying x-ray reproductions is his.

CASE REPORT

Mr. T. B., an unmarried Polish laborer of forty-eight, came to the Kenosha Clinic October 6, 1930, complaining of shortness of breath and cough with bloody expectoration of three weeks' duration. He had continued work until the onset of these symptoms. For three years before he had had a chronic cough associated with a small amount of grayish mucoid sputum. Three weeks before the cough had become abruptly worse. The patient felt that he had developed a severe cold. He had not had a chill nor did he complain of pain. From the onset the sputum had increased in amount and contained bright red blood. Gradually he grew more and more dyspneic on exertion until at the time of admission to St. Catherine's Hospital, October 6, he was scarcely able to walk. He continued to expectorate mucoid material mixed with variable quantities of bright red blood and blood clots.

The patient had always been in good health previously. He had never consulted a physician before. He had always worked out of doors until two years prior to the onset of his present illness, when he was employed in an asbestos factory where he was exposed to inorganic dust much of the time.

Examination revealed a well nourished, middle aged man, moderately cyanotic and in severe respiratory distress. Blood pressure was 140 systolic, 90 diastolic; pulse 90; temperature 100° F.; respirations 30 per minute. The teeth showed extensive pyorrhea and in addition, several necrotic stumps were visible on a level with the gum margins.

The thyroid was not palpable, nor was there any evidence of enlarged glands about the neck. The trachea seemed free from obstruction both from within and without. The chest was round and full. The anteroposterior diameter was greater than the transverse. Inspiratory intercostal retraction was visible on both sides.

The lower right lobe of the lung was dull to percussion and there was an absence of breath sounds over the same area. Over the middle lobe distinct tubular breathing could be heard, changing in character to tubo-vesicular over the upper lobe. The left lung was clear throughout. Over both lung fields one could hear a few shifting, moist rales.

The apex impulse of the heart could not be seen or felt. Cardiac dullness extended 9 cm. to the left of the midsternal line. The region of the right cardiac border could not be determined. The heart sounds were distant, of good quality and regular, but rapid. There were no murmurs.

[1] Norris & Landis—Diseases of the Chest. W. B. Saunders & Co., 1923.

The abdomen was scaphoid and exhibited no gross abnormalities. The liver was palpable about 3 cm. below the costal margin. The edge was fairly firm and smooth. The liver did not move with respiration.

A lipoma about the size of a small lemon was seen in the lumbodorsal region and another of similar size, more or less pedunculated, was located on the upper inner aspect of the left thigh.

After a preliminary examination the patient was transferred to St. Catherine's Hospital.

Urine analyses on numerous occasions revealed no abnormalities. Six blood examinations showed hemoglobin 95 per cent to 75 per cent; red blood cells 5,300,000 to 4,300,000; white blood cells 15,000 to 9,000; neutrophiles 76 per cent to 60 per cent. The Wassermann was negative. Five sputum examinations were negative for tubercle bacilli. Guinea pig inoculation was negative after four weeks.

Five attempts were made to aspirate the right pleural cavity. Each attempt yielded 5 to 15 c.c. bright red fluid. The sediment contained many red cells, a few lymphocytes and endothelial leukocytes; no bacteria. Cultures were sterile after forty-eight hours.

X-ray examinations of the chest made at intervals of approximately seven days showed a rapidly progressive process involving chiefly the right lung, as will be observed from the accompanying x-ray illustrations.

The clinical course was progressively downward. The patient had a low grade fever, rarely above 100° F., throughout his stay in the hospital. The pulse was constantly above 90 per minute. He complained of pain more or less continuously in the right lower chest posteriorly and on both sides of the sternum. At times there was pain in the shoulders and in the region of the thoracic spine, but never severe enough to require opiates. The cough was extremely troublesome both day and night and could be relieved only slightly by the use of codeine. The sputum consisted of pinkish, gelatinous, odorless fluid mixed with bright red blood and at times blood clots. The quantity varied from one ounce to several ounces daily. During the last week the sputum was chocolate colored and was more or less offensive. The patient had lost twenty pounds in weight after six weeks.

Fig. 1. Nov. 7, 1930: X-ray of the right lung suggests a chronic inflammatory process such as might be the result of a tuberculous or other infection.

The respiratory distress became more and more urgent along with a progressive increase in cyanosis. On December 29th the patient could take only liquids in small quantities because of severe dyspnea. December 30th he lapsed into unconsciousness and died four hours later.

NECROPSY-PROTOCOL

External inspection

The body is emaciated. The chest is expanded and barrel-shaped, bulging on both sides. The abdomen is scaphoid. Two lipomas (about 5-6 cm. in diameter) are seen, one in the right lumbodorsal region, and the other at the upper inner side of the left thigh.

Internal examination

The pericardial sac contains about 100 c.c. sero-hemorrhagic fluid. The heart is firm in

Fig. 2. Nov. 25, 1930: The right diaphragm is held immobile at the level of the 5th rib. The heart and mediastinum are drawn somewhat to the right. The left lung shows no changes.

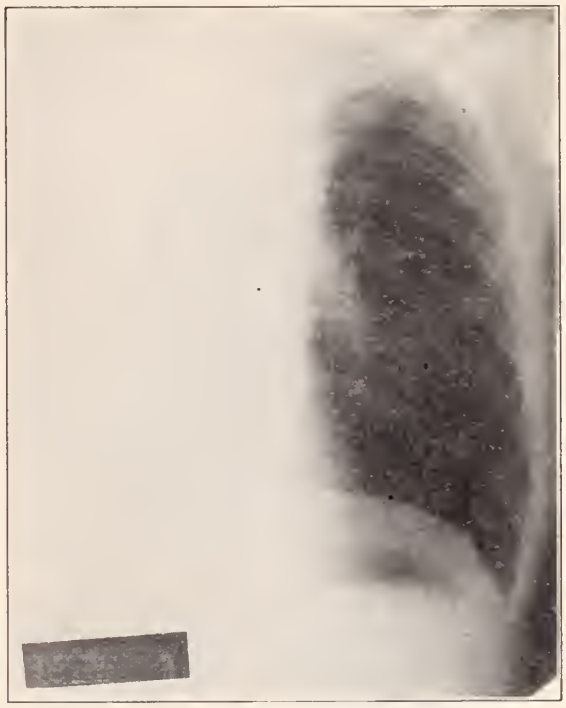


Fig. 3. Dec. 10, 1930: At this time there is a dense homogeneous shadow occupying the entire right side of the chest. No areation of the upper portion of the lung can be seen. The heart shadow is unchanged, except that all mediastinal structures are drawn to the right. The shadow probably represents a progressive involvement of the pleura, together with the presence of a small amount of fluid. The left lung is clear, as was previously found.

consistency and slightly increased in weight (360 gm.). Heart cavities are empty and lined with smooth, shining endocardium. There are no valvular lesions. The walls of the ventricles are markedly thickened, that of the right ventricle measuring .6 cm. in thickness and that of the left 2.2 cms. The first measurement of the aorta is 7 cm. The intima of the ascending aorta is mottled with numerous atheromatous patches.

The whole mediastinal space is filled with a white-colored, bulky tumor mass in which the large blood vessels, the trachea and the main bronchi are firmly incorporated. One globular growth about the size of a fist projected into the left upper posterior pleural space, pushing the left lung forward. There is no free fluid in the left pleural cavity and there are no adhesions between the lung and the chest wall. The lung parenchyma is markedly emphysematous in appearance and spongy and crepitant to touch throughout. The hilus region, including the lymph glands, is incorporated in a tumor mass compressing the vessels and bronchi entering the lung.

In trying to remove the right lung, the right pleural space was found to be obliterated and filled throughout with tumor masses which covered the convex surface of the right lung completely, fixing it firmly to the chest wall. On cross sections the right lung root appears to be converted into compact tumor tissue which shows hemorrhagic areas as well as areas of softening. The vessels and bronchi of the hilus are deeply embedded in this mass and are somewhat compressed. The vessel walls are apparently not penetrated by tumor tissue. From the right hilus the tumor tissue extends into the lung parenchyma, radiating chiefly along the ramifications of the bronchi. The lung tissue between the macroscopically visible tumor-areas is almost entirely solidified. The diaphragm on the right side is covered with tumor vegetations and is adherent to the lung throughout. After removing the diaphragm the liver is seen to be studded with myriads of miliary whitish nodules. We were not

Fig. 4. Cross section of the right lung showing involvement of the hilus and parenchyma, especially the middle and lower lobes. Note how the tumor tissue follows the subdivisions of the right bronchus into the lung itself where it invades all lobes including the pleura.

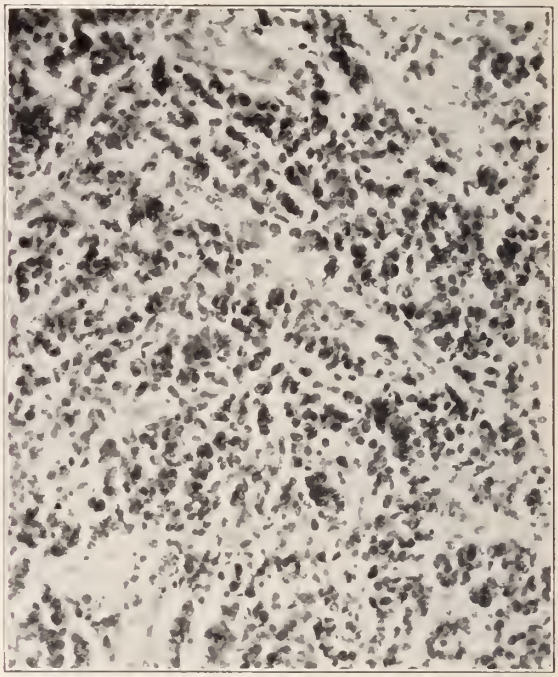


Fig. 5. Photomicrograph of small, round-celled lymphosarcoma of the right lung secondary to the primary tumor occurring in the mediastinum.

permitted to examine the contents of the abdomen, hence further involvement of other organs could not be determined.

Histological study

(a) Mediastinum:

The mediastinal tumor mass shows a dense collection of small round cells having no definite arrangement and scattered through a loose connective tissue base. Many of these round-cell collections are lying in dilated lymph spaces. The cells are quite uniform in appearance, closely resembling lymphocytes and lymphoblasts.

(b) Liver:

The liver cells show cloudy swelling. Focal collections of lymphoid cells answering the foregoing description are seen scattered irregularly through the parenchyma.

(c) Right lung:

Masses of small, dark-staining, round cells of the type described above are seen infiltrating the parenchyma. These cells are seen particularly in peribronchial arrangement and in the lumen of the smaller bronchi, as well as in some of the alveoli. Some of the alveoli are empty and dilated; others are filled with desquamated alveolar endothelial cells. The framework of the lung contains numerous deposits of coal dust.

Diagnosis

(a) Mediastinal lymphosarcoma (lymphocytic type) completely filling the mediastinal space, the right pleural space, and extensively invading the right lung, the hilus of the left lung, and the liver.

(b) Atheromatosis of the aorta ascendens.

(c) Concentric hypertrophy of the heart.

Death was due to asphyxia resulting from compression of the main bronchi and large blood vessels in the mediastinum by a bulky lymphosarcomatous new growth.

CORRELATION OF CLINICAL AND ANATOMICAL DATA

Viewing the clinical and anatomical findings in retrospect, we encounter but few

discrepancies. While the beginning of the tumor growth cannot be determined from the history, the progressive invasion of the right lung as shown by a series of x-ray studies is indicative of a rapidly growing tumor which infiltrated the neighboring structures in a comparatively short time.

The cough of which the patient complained for three years prior to the onset of acute symptoms cannot, in our opinion, have any close relationship to the mediastinal new growth. The appearance of blood in the sputum late in October undoubtedly marks the beginning invasion of the right lung by tumor tissue.

The first x-ray picture, taken November 11th, shows only moderate involvement of the lung. The contrast between the early onset of marked local symptoms such as hemoptysis, dyspnea, etc., and the late development of cachexia was obvious. This is explained by the fact that mediastinal lymphosarcomata are largely local processes, and that metastasis, if any, usually occurs late.

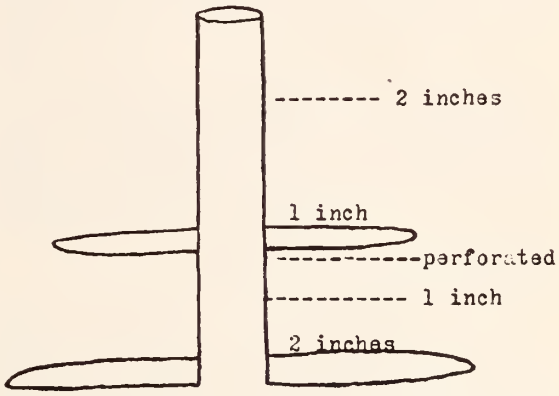
Comparing the later x-ray pictures with the clinical and anatomical findings, one sees a graphic illustration of the difficulty encountered in differentiating between infiltrative new growths and inflammatory lesions of the lung. The dense, uniform shadow occupying the right thoracic cavity as shown on December 10th was produced by tumor vegetations covering the entire surface of the right lung. Despite the indefinite x-ray findings, the clinical course of the disease was not that of an inflammatory process.

New Drainage Tube for Promoting Adequate Drainage Following Thyroidectomy

By W. J. TUCKER, M. D.
Ashland

After the most careful hemostasis in thyroid surgery, it has been a matter of chagrin to note swelling of the neck as result of inadequate drainage of blood or serum. The present system of drainage by tube or gauze has not been satisfactory, because while providing for drainage from one lobe it does not provide for drainage from the other lobe and totally blocks drainage from under the skin.

The following tube has been devised. Ordinary size rubber tubing five inches in length is used. It is split two inches from the end and flaps thus created are sutured by silk to a right angle to the tube. Beginning one-half inch above this flange a section of one inch on both sides is cut from the walls of the tube and this in turn is sutured at a right angle leaving a tube as pictured



in the illustration. The lower flanges are directed towards each lobe,—muscles sutured in the midline,—the upper flanges are placed under the skin and the skin closed. It has the added advantage of not being easily displaced.

Wisconsin Fifth in Percentage of J. A. M. A. Subscriptions

In only four other states are there more physician subscribers to the Journal of the American Medical Association than in Wisconsin, according to a report of the Board of Trustees of the A. M. A. Arizona leads the list with a percentage of 78; New Jersey, 75%; Connecticut, 70%; Illinois, 69%, and Wisconsin fifth with 68%. The number of physicians in the state is 2,987 of which 2,203 are members of the State Society and 2,035 subscribers to the Journal of the American Medical Association.

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EDITORIALS

ANOTHER WISCONSIN "EXPERIMENT"

AT THE Mississippi Valley Conference meeting at Rockford, Illinois, last autumn, it was very gratifying to the civic pride of the more than 120 Wisconsin citizens in attendance, that our own Lake Tomahawk State Camp for convalescents from tuberculosis shone out as the preeminent institution of its kind in the United States. We suspect, however, that many of our Wisconsin delegates,—notwithstanding their highly specialized interest and knowledge of tuberculosis—did not themselves realize how much attention the Camp has been attracting outside the borders of Wisconsin.

Even fewer Wisconsin physicians, we believe, have anything like an adequate appreciation of this great pioneering establishment in salvaging male, ex-sanatorium tuberculosis patients. Similarly effective provision should follow soon for reenforcing women to resume their places in the work-a-day world after sanatorium treatment. H. E. D.

WE NOMINATE

SOMEWHERE among all our American institutions, place should be made for those who have distinguished themselves for faulty reasoning. And for such a hall do we nominate the member who resigned from his county and state society "for the following reasons:

"1. Too much county and state medicine.

"2. Too much socialized medicine.

"3. Too much nothing left for the private general practitioner who is the true foundation of the art."

We look forward with interest to the reforms he will accomplish single-handed when medical organizations sometimes find themselves pitted against foundations endowed for upwards of a million dollars, not to mention agitators for fascist or soviet types of "democratic government."

The resigning member should make the acquaintance of Mark Twain's character who advocated abolishing beds because so many people died in them.

CHRONIC APPENDICITIS
(Clinical Entity?)

IF CHRONIC appendicitis is a clinical entity, what is this entity? Such a diagnosis is made on what basis and what is the result of treatment? We are given satisfactory descriptions of acute appendicitis, such as: pain, nausea or vomiting, increased pulse, temperature and leukocytosis, abdominal rigidity, tenderness and often a palpable mass; but similar succinct descriptions of chronic types of the disease are wanting.

Chronic appendicitis has been divided into: one that follows, and another that does not follow an acute attack. The for-

mer is characterized by intermittent attacks of mild pain, epigastric distress, occasional nausea and more or less gaseous distention; a syndrome that at times is impossible to differentiate from a "mild chronic cholecystitis, a typical duodenal ulcer, or a mild chronic pancreatitis." In the latter, the onset is gradual, with indigestion, slight abdominal discomfort, mild intestinal distention and constipation; violent exercise or fatigue cause right lower abdominal discomfort and not infrequently, pain. In an attempt at a short, concise, summary of these symptoms and signs, one is impressed by the vague and indefinite descriptive words, e. g. indigestion, abdominal discomfort, distress, distention, which are rendered still more obscure by the use of modifying terms, e. g. more or less, occasional, mild, slight.

Confusion is increased by the admission that the disease may come on with or without pain, and that it is characterized by a syndrome that may not be differentiated from other common abdominal diseases. Because of the uncertainty of the above symptomatology diagnostic stress is often placed upon skillful palpation. In view of the fact that the above enumerated symptoms and signs are far from characteristic; augmented by the fact that all of these symptoms and signs persist, in an appreciable proportion of cases, *after* appendectomy for chronic appendicitis, one may say that the clinical entity of chronic appendicitis is at least doubtful. And this doubt is increased by noting in many acute operative cases that the appendix shows thickening, hypertrophy, adhesions, obstructions and even enteroliths, unquestioned previous chronic appendicitis; but, between acute attacks, these patients are usually symptom free. For this discussion to be of practical value some method of judging the accuracy of the diagnosis is necessary.

The treatment of appendicitis may be subjected to unusual and very satisfactory control. Appendectomy is the recognized method of treatment, and if performed before complications arise, the results are satisfactory. In acute appendicitis, post operative continuance of symptoms suggests an incorrect or incomplete diagnosis. The same logic must hold in chronic appendicitis.

With remote results as a criterion for judging the accuracy of the diagnosis, one is led to the conclusion that the diagnosis of chronic appendicitis may not be made, with accuracy, before (from history, physical examination, laboratory or x-ray findings), during (by inspection or palpation) or after (by gross or microscopic examination) operation; and that the condition does not cause symptoms sufficiently characteristic to justify the diagnosis. The question is important and not purely academic because of its intimate association with the disconcerting increase in mortality rate of acute appendicitis due, largely, to late surgery. Reluctance on the part of the patient to accept proper treatment is many times because of a lack of confidence, engendered by knowledge of supposedly similar cases (acute and chronic not being differentiated) in which symptoms have persisted, or returned, after operation.

By securing more frequent satisfactory results in chronic cases, in other words, by making proper diagnosis; correct treatment will be accepted earlier in acute cases, with a lowered mortality rate.

It has been claimed that the freedom from future attacks, metastatic infection, or death; makes the patient better off with the appendix out, despite a return of the original symptoms. This advocacy of prophylactic appendectomy as a compensatory benefit for: incorrect diagnosis, improper treatment and unsatisfactory results seems rather strained. This question of prophylactic operation may be frankly discussed, its advantages and disadvantages explained to the patient who should decide, and who, in all fairness, should not unknowingly be subjected to prophylactic appendectomy under the mistaken diagnosis of chronic appendicitis. Until its signs and symptoms can be concisely outlined, as in acute appendicitis, one must doubt the clinical entity of Chronic Appendicitis. F. G. C.

THE PRESIDENT'S PAGE

C. A. Harper

THE FAMILY PHYSICIAN

THE passing of the family physician has been the subject of much speculation by various writers as to the relationship between the public and the medical profession. Studied from the human relationship between the physician and his clientele, there may be much to be regretted. Next to their God did the people give reverence to their family physician. He frequently was the trusted advisor on many intimate family affairs and his counsel was frequently sought as a free superagent in his administrations. It is hard to efface, if it can be effaced at all, the picture and ties in the weal of the common good that the doctor of the old school played upon the stage of human relationship. He performed in an empirical age in contrast to the scientific arena of today.

The rapid advance of medical science led to specialization—the surgeon, oculist, internist, pediatrician, obstetrician, etc.,—until the identity of the family physician became obscured if not obliterated. With the specialists within the medical profession came specialists of the healing art from without, and many cults found fertile fields in which to operate. It would appear that the elimination of that bond of human relationship between the family physician and his patient may be a potent factor in initiating cultism.

The value of the specialist within the profession cannot be questioned. If such specialization could be brought about with the family physician still holding intact the reverence that formerly existed, probably many non-medical paths to the healing art would never have been trodden. With the recent advances made in the field of prevention, the family physician could fill a vitally important role. His new armament compared with his crude equipment of former years could be made a mighty weapon of protection. His close relationship to his family charges would naturally enable him to bring about practically universal immunization against smallpox and diphtheria. The undernourished children would be early observed and ways and means devised to bring them up to normal, thereby reducing to a marked degree the incidence of tuberculosis. Knowing his family as he would, he would be a potent factor in lessening the tuberculosis contacts. Of the school children that fail to make their grades, 80% are under and improperly nourished. Others suffering from remedial defects would receive careful attention at the proper time. School economies thereby would be much improved. There would be no dividing of responsibility along the channels of family welfare. On account of his close relationship he would be expected to extend freely his hand of guardianship to willing receivers.

The family physician is needed during the period of unemployment and financial distress as he was needed in the early pioneer days. The family must receive careful consideration and proper protection if efficient citizenship is to be maintained.

Humanity as well as governmental economies are seriously concerned in the health and social balance of the people of the United States. In 1929, it is said that the municipalities of Wisconsin spent over one million dollars in aid to the needy. In 1930, three and one-half million dollars were used for these purposes. In 1931, it is reasonably estimated that nine million dollars will be necessary to prevent undue hardship. A new responsibility therefore rests upon the physician. We need now, more than ever before, a united medical profession to do its part in a constructive way. The medical profession needs a common denominator with carefully apportioned numerators and probably a new specialty—the family physician.

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SOCIETY PROCEEDINGS

BROWN-KEWAUNEE

The Brown-Kewaunee County Medical Society held its April meeting at the Hotel Northland, Green Bay, April 16th.

Mr. B. E. Kuechle, manager of the claims department of the Employers Mutual Liability Insurance Company of Wausau, gave an interesting talk on the various forms of insurance policies that are being issued, and pointed out the way to safeguard the insurance policies that are in force and how to buy the right kind of insurance.

Mr. Edward Duquaine, attorney at Green Bay, gave a talk on the subject of "Wills." He brought out and emphasized many valuable points on this matter.

There was a short business meeting after the scientific part of the program. Reports were made by Dr. O. A. Stiennon, Green Bay, chairman of the public health committee. He proposed a resolution in re bill number 35, S urging its defeat. This resolution was adopted and copies sent to the Secretary of the State Medical Society and to the members of the state legislature.

Following is the resolution:

Whereas: Bill 35, S proposes to make the insurers a party to the defendant in personal injury cases and make no exception to medicine or surgical malpractice suits, and

Whereas: We feel that exception for such cases should be made inasmuch as in malpractice cases in addition to money damages, the reputation for skill and personal character of the physician or surgeon is involved, and

Whereas: We believe that the insurer's interest should not be made material in a malpractice suit, but should be judged solely upon the facts presented, and

Whereas: We feel that if the knowledge that the insurer will pay the award rather than the defendant, is made known to the juror, it may confuse his judgment, to the detriment of the defendant's reputation, the protection of which is not covered by the insurer.

Therefore it is hereby resolved: That the Brown-Kewaunee County Medical Society is unalterably opposed to Bill 35, S without the indicated amendment.

A. J. McCarey, *President.*
E. S. Knox, *Secretary.*

Report was made by Dr. W. E. Leaper, Green Bay, in regard to radio committee's work. The President suggested that this committee continue and complete its work. A communication was read from the Dental Society regarding public health programs and the necessity of an oral hygienist in the city schools.

A rising vote of thanks was given to Mr. Kuechle and Mr. Duquaine. Meeting adjourned. E. S. K.

CHIPPEWA

A meeting of the Chippewa County Medical Society was held at Hotel Northern, Chippewa Falls, on Tuesday, May 12th. Dinner was served at six-thirty P. M. A scientific program was presented as follows:

1. Consideration of Secondary Anemia by Dr. C. H. Watkins of the Mayo Clinic.
2. The Problem of Hypertension by Dr. B. T. Horton, also of the Mayo Clinic.

Twenty-six members attended the meeting.

COLUMBIA

The Columbia County Medical Society and its Woman's Auxiliary met at the Hotel Portage, Thursday evening, April 23rd. Following dinner, the members of the Auxiliary held a short business meeting after which cards were played.

Dr. Ira Sisk, Madison, addressed the Society on "Prostatic Diseases." This was a very interesting and instructive discussion of the more common conditions. Following a free and full discussion the meeting adjourned. H. E. G.

DANE

Members of Dane County Medical Society met at St. Mary's Hospital, Madison, on Monday, May 11th, at eight o'clock.

Some interesting stomach cases were reported by Dr. Rogers T. Cooksey, Madison, including carcinoma grade IV of the stomach in a child seven years of age; a congenital hour-glass stomach; intussusception of the jejunum through an old gastro-intestinal opening as a complication of pregnancy; and spontaneous healing of a gastric fistula following resection.

Dr. Reginald H. Jackson, Madison, gave a case report of primary carcinoma of the liver, illustrated with slides and motion pictures.

Dr. Warren H. Cole of the Department of Surgery, Washington University School of Medicine, St. Louis, spoke on "Infections of the Liver." This subject included a discussion of the etiology of the various grades and types of infections, such as pylephlebitis, suppurative cholangitis, and liver abscess, with the diagnosis and treatment of the above conditions.

GREEN LAKE-WAUSHARA-ADAMS

The Green Lake-Waushara-Adams County Medical Society held its regular monthly meeting at Green Lake, April 24th. Following a six-thirty o'clock dinner served at the Gurdy Hotel, members of the Society met at the court house while the members

of the Woman's Auxiliary held a social meeting in the hotel parlors.

Dr. J. A. Hurlbut of Madison was the speaker at the Society meeting. His subject was "Sinus Disorders."

JEFFERSON

The first meeting of the year for the Jefferson County Medical Society was held at the Washington Hotel, Watertown, April 30th, at six-thirty P. M.

Dr. W. J. Bleckwenn, Madison, presented a paper on "Encephalography in Head Injuries" illustrated by lantern slides. Proposal was made for a joint meeting with the County Dental Society in the immediate future. M. G. P.

LA CROSSE

A regular meeting of the La Crosse County Medical Society was held at the La Crosse Club on April 21st, at eight p. m.

The minutes of the previous meeting were read and were approved as read. Correspondence from Mrs. J. A. L. Bradfield and daughter was read. The letter expressed thanks to the Society for flowers and for attending in a body the funeral of Dr. Bradfield.

The question of closing the offices of the La Crosse doctors on Saturday afternoons during the summer and fall months was brought up for discussion. It was freely discussed by all present, there being much difference in opinion among the various doctors. No action was taken.

Dr. H. K. Tenney of the Wisconsin General Hospital, Madison, gave a talk on "The Treatment of Diarrhea in Children." Discussion followed.

A cafeteria lunch was served in the La Crosse Club cafe following the meeting. R. L. E.

MANITOWOC

Twenty-four members of the Manitowoc County Medical Society attended the dinner at the Hotel Manitowoc when Dr. A. H. Heidner, councilor for the fifth district of the State Medical Society of Wisconsin, addressed the meeting as guest speaker. Dr. Heidner spoke on the value of county medical organizations, stressing the opportunity of better understanding of members, and co-operation for the advancement of the profession through such organizations, and briefly sketched some of the results which had come under his personal observation.

Another meeting of the Manitowoc County Medical Society was held at the Hotel Manitowoc, Manitowoc, on Tuesday, May 19th, following a noon luncheon. Three new applicants were admitted to membership,—Dr. Nathan Schneck, Dr. F. F. Zboralski and Dr. Charles E. Wall, all of Manitowoc.

Miss Alice E. Stenholm of the State Board of Control gave an interesting talk on "The Illegitimate Child with Special Reference to the Children's Code." C. H. B.

MILWAUKEE

The monthly meeting of the Medical Society of Milwaukee County, which was a dinner meeting, was held in the Red Room of the Hotel Pfister on May 8. Following the dinner and brief announcements the program of the evening was presented. The following talks were given:

"The High Cost of Medical Service" by L. F. Jermain, M. D.; "Relieving The County Relief" by Mr. W. L. Coffey, manager of the Milwaukee County Institutions; "Wills And The Administration of Estates In County Courts" by Hon. Michael S. Sheridan, Judge of the Probate Court, Milwaukee County.

This was an unusual type of program, and was enthusiastically received by those present. There were 175 in attendance.

SHEBOYGAN

The Sheboygan County Medical Society met on Thursday, May 7th, at Sheboygan.

Several topics of local interest were discussed.

Dr. A. H. Heidner, councilor for this district, was present and presented his views on some of the problems of the State Medical Society. He also discussed the district meeting to be held in June.

Dr. Leland C. Dietsch of Plymouth was admitted to membership. A. C. R.

NINTH COUNCILOR DISTRICT

A Ninth Councilor District meeting was held at St. Michael's Hospital, Stevens Point, on Wednesday evening, April 22nd. Seventy physicians were present, representing Portage, Wood, Waupaca, Waushara and Marathon counties.

The program consisted of three papers:

"Anemias of Adolescence" was read by Dr. Harold R. Fehland of Wausau; "Head Injuries with Special Reference to Encephalography" by Dr. W. J. Bleckwenn, of the University of Wisconsin; "The Relation of the Laboratory to Clinical Medicine" by Dr. W. D. Stovall, of the State Laboratory of Hygiene, Madison.

Dr. W. G. Sexton of Marshfield was elected as the new president while Dr. Joseph F. Smith of Wausau was re-elected secretary.

The meeting was preceded by a dinner served in St. Stanislaus' church basement.

MILWAUKEE ACADEMY OF MEDICINE

Members of the Milwaukee Academy of Medicine met on April 28th at eight o'clock.

Dr. W. E. Grove, Milwaukee, spoke on "Brain Abscess—Otitic."

Dr. Frederick E. B. Foley, professor of urology, University of Minnesota, presented a paper on "Improved Methods in Surgery of Kidney and Ureter."

The following program was presented at a meeting of the Academy on May 12th.

"Cyst of Spleen—Case Report" by Dr. R. W. Benton, Milwaukee.

"Lung Abscess—Acute and Chronic" by Dr. John L. Yates, Milwaukee.

MILWAUKEE OTO-OPHTHALMIC

The May meeting of the Milwaukee Oto-Ophthalmic Society was held in the Cudahy Tower on Tuesday, the 19th. Dinner was served at six-thirty p. m.

Dr. George F. Suker of Chicago presented a paper on "The Vascular Changes in Various Retinal Lesions".

MILWAUKEE PEDIATRIC

The second meeting of the Milwaukee Pediatric Society for 1931 was held on Wednesday, April 15th.

M. V. O'Shea, professor of education, University of Wisconsin, was the speaker of the evening. His subject was "Problems of Childhood." F. R. J.

UNIVERSITY OF WISCONSIN

The University of Wisconsin Medical Society sponsored two lectures during May. The first lecture was given by Dr. Warren Cole of Washington University on May 13th, his subject being "Experimental Lesions of the Thyroid." Dr. Leland S. McKittrick of Harvard University Medical School lectured on "Circulatory Disturbances of the Extremities," on May 18th. Both addresses were given in the Service Memorial Institutes building.

NEWS ITEMS AND PERSONALS

A bronze plaque was awarded the city of Racine through the Racine Association of Commerce by the United States Chamber of Commerce at Atlantic City, N. J. Dr. W. W. Bauer, city health commissioner, received the award on the part of the city. It was given to Racine for its outstanding activities in health work, first place in cities of class four, being its standing. A rising vote of honor was extended to Dr. Bauer at a meeting of the Racine County Medical Society on April 2nd.

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Dr. O. A. Shaw of Ashland returned the latter part of April from a five months' sojourn in southern Florida.

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Dr. H. P. Greeley was re-elected president of the staff of Madison General hospital. All other officers were also re-elected. They are: Drs. R. T. Cooksey, vice-president; L. V. Littig, secretary, and H. M. Kay, treasurer.

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Dr. C. F. Harris, formerly of Stanley, has moved to Fort Collins, Colorado. Dr. W. T. Austin of Fall Creek, Wisconsin, has taken over Dr. Harris' practice.

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A public community farewell program was tentered to Dr. Francis P. Daly of Reedsburg, who practiced in that vicinity for the past thirty-five years. Dr. Daly was recently appointed deputy health officer for the fourth district and is now making his home in Eau Claire. About five hundred attended the program, which was followed by dancing.

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Miss Ruth Buellesbach, R. N., has been chosen as assistant to the secretary of the State Medical Society of Wisconsin. Miss Buellesbach was formerly an instructor in surgical nursing and supervisor of the surgical floor of the Wisconsin General Hospital, Madison.

Dr. W. C. Reineking of Lakeview Sanatorium, Madison, spoke before a meeting of the Lions Club of Stoughton at Hotel Kegonsa on April 27th.

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Dr. Albert Butler, formerly of Great Falls, Montana, has joined the Dodd Clinic, Ashland, as a specialist in eye, ear, nose and throat diseases.

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Dr. W. D. Stovall, director of the State Laboratory of Hygiene, Madison, spoke on cancer before a meeting of the Madison Technical Club at the Park Hotel on May 4th.

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Drs. James W. McGill and J. H. Weisberg were re-appointed school doctors for the city of Superior for the ensuing year.

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Dr. R. B. Dryer, formerly of Detroit, Michigan, has opened an office in Morrisonville, Wis.

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Dr. William S. Middleton, associate professor of medicine, University of Wisconsin, and Dr. C. H. Bunting, professor of pathology, attended the meeting of the Association of American Physicians at Atlantic City, N. J.

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Dr. Eugene E. Neff has returned to Madison after spending some time in study at the New York Eye and Ear Infirmary.

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State Board of Health staff members were guest speakers on May 1st at Milwaukee and Chicago programs in observance of National Child Health Day. Dr. Charlotte J. Calvert, director of the Bureau of Child Welfare, addressed the Chicago Council of Medical Women on the subject of maternal mortality in Wisconsin, and Dr. G. W. Henika, assistant state health officer, was on the program of the Mothercraft Society of the Milwaukee Maternity Hospital and Dispensary Association.

Dr. and Mrs. D. B. Hamilton of Dodgeville sailed on May 15th for a visit to England, Scotland, Ireland, Belgium, Holland and France. They expect to arrive home about July 15th.

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The new Madison Clinic of Physio-Therapy at 204 Monona Avenue, Madison, was opened on May 1st. Dr. C. A. S. Gundersen is the medical director and is assisted by Dr. T. A. Hagerup, formerly surgeon at Lutheran Hospital, Dodgeville.

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Dr. Neil Andrews of Oshkosh was confined to his home late in April when he was taken ill with pneumonia. Dr. Andrews contracted a cold in New York as he disembarked from the ship on which he returned from a trip to Italy.

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Dr. Stuart A. McCormick, Dr. Everett B. Keck and Dr. William A. Werrel announced the first week in May the opening of joint offices at 407-412 State Bank of Wisconsin Bldg., Madison.

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Dr. Malcolm G. Millar, formerly of Mobridge, South Dakota, has moved to Madison and is now resident physician at the State Orthopedic Hospital.

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Pollution and erosion problems of the upper Mississippi valley were discussed at the regular noon luncheon of the Shrine Club on May 8th at the La Crosse Hotel by Dr. Alf Gundersen, member of the board of directors of the La Crosse Izaak Walton League.

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At a meeting of Shawano physicians, the following were elected officers of the new Shawano hospital: president, Dr. W. H. Cantwell; vice-president, Dr. C. E. Stubenvoll; Dr. Lyndle Peterson, secretary.

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Dr. F. P. Dohearty, Appleton, was re-elected city health officer at a meeting of the Appleton Board of Health in May. Dr. Carl Neidhold was again named President of the Board.

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Dr. Victor S. Falk of Stoughton has sold his practice and interest in the Stoughton Clinic to other members of the Clinic and is now sailing with Mrs. Falk for an extended tour of Europe which will be followed by a several months period of post-graduate study in internal medicine in Vienna. Upon completion of his studies, Dr. Falk will return to the United States. His plans following his return have not yet been made.

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The 6th volume of the published proceedings of the Inter-State Postgraduate Medical Association of North America which contains 36 clinics and 78 addresses as presented at the International assembly held at Minneapolis, October 20–24, 1930, is now available. The volume is liberally illustrated and includes portraits of the President and of the foreign guests of the Association. Orders should be forwarded to Dr. Edwin Henes, Jr., executive secretary, 759 North Milwaukee Street, Milwaukee.

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Dr. T. J. Snodgrass, Janesville, claims the record as a trout fisherman with a rainbow caught in the Brule shortly after the opening of the season.

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Dr. W. L. Herner of Sacred Heart Sanitarium, Milwaukee, came to Madison on May 19th to appear before the legislature with Mr. J. G. Crownhart, secretary of the State Society, in favor of an amendment to exempt institutions for the care of the sick under the proposed eight-hour day law.

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Dr. J. A. E. Eyster, professor of physiology, University of Wisconsin, represented the University at the meeting of the American Association of Physicians and Surgeons at Atlantic City, N. J.

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Dr. Wilfred G. Riopelle, Beaver Dam, visited the offices of the State Medical Society, Madison, on May 21st.

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Mrs. Annie Green, 83, mother of Dr. M. K. Green, superintendent of Wisconsin State Hospital for Insane at Mendota, died on May 17th in Madison.

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Dr. F. A. Boeckman, formerly of Greenwood, on May 15th began his duties as a member of the staff of the Marshfield Clinic.

MILWAUKEE

Dr. Francis D. Murphy spoke before the District Medical Meeting at Viroqua on May 19. His subject was "Heart Failure—Its Diagnosis and Treatment."

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Following several months of effort, an arrangement was entered into between the Medical Society of Milwaukee County, the Milwaukee Hospital Superintendents' Association, the Physicians' Service Bureau, and the Milwaukee County Institutions whereby the private hospitals and the medical profession agreed to assume responsibility for the "border line" cases, or those temporarily distressed because of economic conditions. Mr. W. L. Coffey in commenting on this to the press said, "This movement by the Medical Society and the hospitals will do much to relieve the county hospitals and fill the gap. We have unusual demands made upon us by these 'border line' cases and I am sure they would prefer private attention."

Among the hospitals which are providing hospital service on a credit basis for those temporarily financially distressed are Columbia, Mt. Sinai, St. Josephs, St. Marys, Deaconess, Milwaukee, Misericordia, and St. Luke's Hospitals. Charges made will be

as low as possible, and methods of payment made according to a system adopted by each hospital.

In a statement to the press, Dr. E. L. Tharinger, President of the Medical Society of Milwaukee County, said, "The Medical Society is gratified with the action taken by the hospitals. The Health Council suggested this step several months ago. A number of physicians are extending credit as are some of the hospitals, but organized effort to care for the people who have gone unwillingly to the county and other charitable institutions has been needed. There is danger that some may take unfair advantage but the welfare of the public must be considered first. All we ask is for the patient to be frank and honest."

Mr. L. C. Austin, President of the Hospital Superintendents' Association, was spokesman for the hospitals. He pointed out that the person who owns a home but is financially short must be cared for by extended credit on hospital costs.

Dr. Ralph P. Sproule, Chairman of the Health Council, originated and stimulated this plan.

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It was definitely decided, at a meeting of the board of directors on May 8, to establish the Medical Business Bureau which will be operated under the supervision of the Society. Mr. Gregory Gramling, attorney for the Society, will manage the Bureau. Detailed plans will be available as soon as the committee on collection service has developed its plans. Dr. C. M. Echols is chairman of this committee, and Drs. J. W. Powers and R. A. Toepfer are members.

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The Social Committee of the Society, at its last meeting, developed preliminary plans for the annual picnic, to be held the latter part of June. If satisfactory arrangements can be made the picnic will be held at Golden Lake, near Sullivan. The outing was highly successful last year and was attended by over 250 physicians and their families. An ambitious program is being planned.

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Dr. H. W. Powers, a member of the Speakers' Bureau of the Medical Society of Milwaukee County, gave two talks early in May. On May 4, he addressed the Dover Street School Parent-Teacher Association on the subject of "Character Formation in the Child."

On May 5th he spoke to the Milwaukee County Hospital Nurses on "Delinquency in Children And Its Treatment."

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Mrs. Arthye M. Toepfer, wife of Dr. R. A. Toepfer, of West Allis, passed away, after a brief illness, on Tuesday evening, May 5. She is survived by Dr. Toepfer and three children, Joan, and twins, Phyllis and Lorraine.

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At a staff meeting of the Muirdale Sanatorium on May 5, Dr. L. L. Allen read a paper on "Early Diagnosis Of Pulmonary Tuberculosis."

The Military Order of Foreign Wars, composed of officers who have served in the wars of the nation, held its annual meeting in Milwaukee on April 25. The following members of the Medical Society of Milwaukee County were elected to office: Major R. W. Blumenthal, surgeon, and Captain W. C. Liefert, adjutant. At the dinner given on Saturday evening, April 25, Dr. Gilbert E. Seaman, who is a colonel in the organization, spoke.

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Announcement has been made of a 60-bed addition to Columbia Hospital. This new portion will give the hospital a total of 160 beds. It will contain private rooms mostly, but will also have several wards. This will greatly relieve the over-crowded condition from which the hospital has suffered recently.

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At the child health day dinner of the Mothercraft Class of the Maternity Hospital and Dispensary Association, held May 1, Dr. John P. Koehler, City Health Commissioner, outlined the progress in community health in Milwaukee since 1912. Among the other speakers on the program was Dr. M. W. Sherwood, chief of staff of the Milwaukee General Hospital.

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Dr. and Mrs. William Jobse are in New York at the present time visiting their daughter, Mrs. Norman Scott.

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The following talks, sponsored by the Speakers' Bureau of the Medical Society of Milwaukee County, were broadcast over the Marquette University Radio Station WHAD during the month of May:

May 6—"The Value Of Life From An Economic Aspect" by Dr. E. V. Brumbaugh.

May 13—"Occupation And Tuberculosis" by Dr. A. L. Banyai.

May 20—"Insomnia" by Dr. John L. Garvey.

May 27—"Delinquency And Character Formation" by Dr. H. W. Powers.

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Dr. Samuel G. Higgins spoke at the annual dinner meeting of the Minnesota Academy of Ophthalmology and Oto-Laryngology held in Minneapolis on May 8. His subject was "Closure Of The Cataract Incision—Corneal Conjunctival Suture". At the close of the meeting, Dr. Higgins was elected an honorary member of the Society.

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The Physicians' Service Bureau membership committee, of the Medical Society of Milwaukee County, has just concluded its drive for members for the Bureau. Two hundred sixty-nine members were obtained. The Bureau serves as a connecting link between doctor and patient and acts as a medical information bureau for the city and county of Milwaukee as well. Calls for information concerning physicians, institutions, and requests for miscellaneous information have increased several hundred each

month. This is a 24-hour service, employing four operators.

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Drs. John L. Yates, Arthur T. Holbrook, and E. A. Fletcher have returned from a northern trout-fishing trip.

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Dr. W. C. F. Witte gave an illustrated talk on Advanced Surgery to graduates of St. Mary's Hospital, at a dinner held in the Hotel Wisconsin on May 19th.

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Dr. Frank Darling addressed the senior class of St. Rose's School of Nurses at a dinner given in the Hotel Schroeder on May 19th.

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At a staff meeting of Muirdale Sanatorium on May 19, Dr. J. P. Fetherston presented a paper on Artificial Pneumothorax.

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Dr. and Mrs. W. J. Carson left for a trip through the South on May 18th.

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St. Anthony's Hospital erected on Tenth Street, between State Street and Highland Avenue, to serve negro patients as well as white, was dedicated on Sunday, May 10, by Archbishop Samuel A. Stritch. Training courses for negro nurses will be provided. The institution will be in charge of the Franciscan Sisters of Little Falls, Minnesota, and will be opened for patients about May 20th.

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Mr. W. L. Coffey, manager of the County Institutions, announced on May 9th that an intensive effort is going to be made to check the financial records of "indigent" patients at the County Hospital and the Emergency Dispensary unit. Mr. Coffey said that the County will be districted for investigation work as soon as the organization staff is completed. He further stated that the home and financial conditions of about 25,000 applicants who have applied for aid, and thousands of persons who have been given medical treatment will be checked by investigators by next September or October. The County will demand payment by those who are able to pay. The investigators are to be trained for their work in a course established by Mrs. Margaret Wilson and Mrs. Ella Joyce, who are experienced county investigators and are directing the investigations of the staff.

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At a meeting of the Committee on Collection Service on May 11th, it was definitely decided that the name of the collection service should be the Medical Business Bureau of the Medical Society of Milwaukee County. It was further decided that this Bureau should open in the Mariner Tower (606 W. Wisconsin Avenue) on June 1st. The Bureau will be under the supervision of the Society and under the management of Mr. Gregory Gramling.

The Speakers' Bureau of the Society was represented during the month of May by Drs. H. W. Powers and Carl W. Eberbach. Dr. Powers spoke before the Parent-Teacher Association of the Dover Street School on May 4th. His subject was Character Formation in the Child. On May 5th, he addressed the Milwaukee County Hospital Nurses Group on Delinquency in Children and Its Correction, and on May 18th he appeared before the Jefferson School Parent-Teacher Association, where he spoke on Character Building in Young Children.

Dr. Eberbach addressed the Professional Men's Club at the Milwaukee Athletic Club on May 18th. His subject was The Goiter Problem in Great Lakes District.

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Dr. Benjamin E. Urdan has announced the opening of his office for the practice of Gynecology and Obstetrics in the Goldsmith Building, located at 425 E. Wisconsin Avenue.

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A plan whereby the food handlers of Milwaukee would be required to have physical examinations was advanced by Dr. John P. Koehler, City Health Commissioner, at a meeting of the Health Advisory Committee of the Medical Society of Milwaukee County on May 12th. Means for carrying out this plan were discussed at some length. As soon as a definite decision has been reached, a detailed plan will be given out.

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The Membership Committee at its meeting on May 15th discussed plans for increasing the membership of the Society. Under the new constitution and by-laws, four classes of membership have been provided,—senior, junior, intern, and associate memberships. A large number of interns have recently become members of the Society. The dues for this class of membership are very small and many interns are taking advantage of affiliating themselves with organized medicine.

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Due to the increase in incoming and outgoing calls at the Physicians' Service Bureau it has been found necessary to add another trunk line to the switchboard. There are now four incoming trunk lines and as soon as the new Medical Business Bureau is in operation there will be an extension from the Physicians' Service Bureau switchboard, which may necessitate another addition to the trunk line.

At the time the last telephone directory went to press on April 30th, 265 members were listed with the Bureau.

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Miss Mary Laffey, who has been doing secretarial work in the executive offices of the Medical Society of Milwaukee County since the inauguration of its new program a year and a half ago, resigned on May 15th to accept a position with Dr. Ralph P. Sproule.

The Insulin Course sponsored by the State Medical Society and the University of Wisconsin Extension Division, in Milwaukee, was a decided success. Seventy physicians attended the afternoon sessions, and about 300 persons were in attendance at the evening lecture which was open to the public.

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The following health talks, sponsored by the State Board of Health, and delivered by Mr. Theodore Wiprud, executive secretary of the Medical Society of Milwaukee County, will be given over the Milwaukee Journal Station, WTMJ, during June:

June 2—Health and Hot Weather.
June 16—Shock.
June 23—Sunlight.
June 30—The Prevention of Some Common Skin Diseases.

The time allotted to the Society for the health talk on June 9th has been relinquished to Dr. Rhode, president of the Milwaukee County Dental Society, who will discuss care of the teeth. These talks are broadcast at 6:00 P. M., each Tuesday.

These health talks will not be broadcast during July and August, but will be resumed in September.

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Dr. E. A. Fletcher was host at a dinner which he gave for members of The Milwaukee Hospital Interns' Association at the Milwaukee Club on May 13th. Following the dinner Dr. Fletcher spoke on some problems in urology which are of importance to young men in medicine, and Mr. Theodore Wiprud, executive secretary of the Medical Society of Milwaukee County, talked on meeting current medical problems in Milwaukee.

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Dr. E. L. Tharinger, President of the Medical Society of Milwaukee County, addressed the Shorewood Men's Club on May 28th.

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The Educational Committee at its meeting on May 14th discussed plans for postgraduate courses. The courses sponsored by this Committee in the past year have been so successful that the Committee has been encouraged to sponsor a comprehensive plan for postgraduate courses in diseases of the heart, applied radiology, common diseases of the eye, ear, nose, and throat, diet, fracture management, office orthopedics, and diseases of the gastrointestinal tract. Plans were completed for a demonstration of the periodic health examination forms developed by the Committee, and the services of a physician specializing in diagnosis will be obtained to demonstrate the proper use of the new form.

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Dr. E. L. Miloslavich, director of the department of clinical pathology and medical research at St. Mary's Hospital, was nominated, on account of his research work in the field of physical anthropology, as Fellow of the American Association for the Advancement of Science.

BIRTHS

A daughter to Dr. and Mrs. Maurice Olsen, Milwaukee, on May 11th.

ENGAGEMENTS

Announcement has been made of the engagement of Dr. Leon H. Hirsh, Milwaukee, to Miss Jule Davidson.

MARRIAGES

Dr. George A. Kriz, Milwaukee, to Miss Laura Gaterman, on April 24th in Elgin, Illinois.

Dr. F. H. Zimmerman, Watertown, to Miss Ruth Czamanske, Sheboygan on May 7th in Sheboygan.

DEATHS

Dr. R. B. Clark, Monroe, died on May 4th at his home of heart disease and complications.

Dr. Clark was born at Orfordville, Rock County, February 18, 1861. He was a graduate of Rush Medical College in 1887, and in 1881 began the practice of medicine in Clarksville, Iowa. Before coming to Monroe in 1894, he had practiced in Brodhead and Juda. In 1906 he founded a drug store in Monroe which is now operated by his son. Dr. Clark had long been a surgeon for the Illinois Central railroad.

He was a member of Green County Medical Society, the State Medical Society and the American Medical Association.

Dr. Clark is survived by his mother, his widow and one son.

Dr. A. D. Daniels, Rhinelander, died on May 7th following a long illness.

He was born in the year 1853 and graduated from the Detroit Medical College in 1876. He practiced medicine in Neenah, Winneconne, and New London before coming to Rhinelander forty-two years ago. He had retired from active practice in 1912. Dr. Daniels was founder of the Oneida Gas Company, the First National Bank, and the Daniels Manufacturing Company at Rhinelander.

He is survived by his widow and one son.

Dr. Charles E. Ide, Milwaukee, died on May 4th at Columbia Hospital, Milwaukee. He was formerly medical director of Muirdale Sanatorium, Wauwatosa.

Dr. Ide was born at Hopkington, Mass., in 1874. He attended Beloit College and received his medical degree from Rush Medical College in 1900. From 1902 to 1918 he was engaged in private practice at Redlands, California. During the World War, Dr. Ide was a captain in the reserve medical corps of the Army. He was stationed at United States Tuberculosis Hospital No. 21 at Denver. In 1920, he entered the United States public health

service and was stationed at Whipple Barracks, Arizona for a year. He returned to Milwaukee early in 1921 to become director of Muirdale Sanatorium.

Dr. Ide was a member of the Milwaukee Academy of Medicine, the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

He is survived by his widow and two sons.

Dr. George H. Young, Elkhorn, died on May 5th at his home in Elkhorn.

Dr. Young was born in 1853 and was a graduate of Bennett Medical College, Chicago, in 1881. He had practiced medicine in Elkhorn for 55 years. In September, 1929, Dr. and Mrs. Young celebrated their golden wedding anniversary. At the same time, Dr. Young was given national recognition as one of the last of the old country doctors. Dr. Young's father was the first physician in Walworth County.

He is survived by his widow and two sons, Dr. Howard Young of Elkhorn and Dr. Will Young of Fort Atkinson.

SOCIETY RECORDS

NEW MEMBERS

Paul E. Craig, Winneconne, Wis.

Helen Pratt Davis, Wisconsin General Hospital, Madison.

Ruth Caldwell, Wisconsin General Hospital, Madison.

George H. Schlenker, Amherst.

Leonard M. Smith, 306 First National Bank Bldg., Oshkosh.

William M. Smith, 306 First National Bank Bldg., Oshkosh.

Thomas L. Johnston, Racine.

J. W. Monsted, Sr., New London.

J. W. Tanner, Eau Claire.

Samuel L. Henke, Eau Claire.

W. B. Diamond, 224 W. Washington Ave., Madison.

Changes in Address

R. J. Winkler, Appleton to Hilbert, Wisconsin.

W. T. Austin, Fall Creek to Stanley.

Chas. F. Harris, Stanley to Box 57, Fort Collins, Colo.

J. E. Johnson, Amery to Grantsburg.

Resignations

H. L. Hulett, Milton, Wisconsin.

P. Langland, Milwaukee.

C. J. Maercklein, Sheboygan.

Maxwell Lando, Mendota.

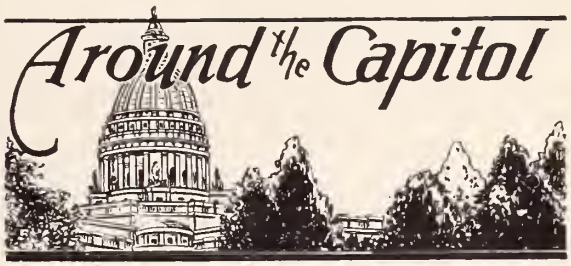
B. F. Johnson, Mondovi.

J. W. McGrath, Milwaukee.

R. D. Boynton, Kilbourn.

P. J. Noer, Wabeno.

C. F. Spencer, Spokane, Wash.



Five important causes of death in Wisconsin showed increased harvest for the first three months of 1931 as compared with the corresponding period in 1930.

Pneumonia proved the leading death cause, claiming 878 lives as compared with 777 in the first quarter of 1930. Cancer stood second with a toll of 854 Wisconsin lives, an increase of six deaths over the 1930 item; and violence was third with 602 deaths as compared with but 504 for the same period of 1930.

Tuberculosis, which is gradually being overcome in Wisconsin, struck back during the past quarter to claim 332 lives as compared with 314 a year ago, and a serious wave of influenza cost the state exactly 300 lives in the three-month period, an increase of 102 deaths over those of the 1930 quarter.

* * *

For the first time in the annals of the State Bureau of Vital Statistics, Wisconsin's rural infant mortality rate was higher than the urban rate, a study of the 1930 statistics revealed. Rural deaths of children under one year of age numbered 56.2 per 1,000 live births as compared with the urban rate of 55.1 for the year. The rural classification includes cities up to 10,000 in population.

* * *

The death rate of Wisconsin Indians is two and one-half times greater than that of whites, according to Dr. C. A. Harper, state health officer.

Dr. Harper says the state board of health favors erection of a sanatorium in the northern part of the state to check the heavy spread of tuberculosis. State and federal nurses in Indian service in Wisconsin agreed that this is the logical procedure.

Last year's federal census showed an Indian population of 10,301 in Wisconsin, while deaths numbered 264. This establishes the Indian death rate at 25.6 per 1,000 population, Dr. Harper pointed out.

* * *

A total of 56 deaths from auto accidents in March brought the Wisconsin toll to 161 for the first quarter of 1931, an increase over the corresponding figure for 1930, that if continued, will mean a year's record of 1,214 automobile deaths as compared with last year's 815.

* * *

It is a trifle easier to remain alive in rural than in urban Wisconsin, according to tabulations released by the bureau of vital statistics, state board of health.

Urban deaths, representing deaths in cities of more than 10,000 population, reached a state total of 13,728 last year, while rural deaths numbered 16,760 during the period. The urban population represents 43 per cent of the state population, however, and urban deaths formed 45 per cent of the total deaths, while the rural population, which is 57 per cent of the state population, suffered only 55 per cent of the deaths.

* * *

Prehistoric Wisconsin Indians were not always the perfectly healthy specimens that some people have imagined, according to Alton K. Fisher.

Twenty-five per cent of the skulls examined by Mr. Fisher showed signs of abscessed teeth, some of the skeletons showing curvature of the spine, while a number gave unquestionable evidence of arthritis deformans, a type of rheumatism affecting the bones.

In one specimen an arrow head was found on the inner side of the spine, evidently having entered through the abdomen. The unfortunate victim had lived six months after being shot, for the arrow head was partly overgrown by bone and there were evidences of suppuration in that region of the spine.

A Social View of Medicine*

By JOHN A. LAPP,
Director Department of Social Sciences,
Marquette University, Milwaukee

Secretary Crownhart: First, I wish to introduce the Secretaries' Conference to Dr. Lapp. Dr. Lapp, it might be said that the group in this room constitute the key men of medicine in Wisconsin. They are the representatives of some 2200 members of the State Medical Society, and no one is more keenly interested in public medicine than are these men who are to guide the destinies of the entire membership.

To the members of this conference, it is with a very real sense of responsibility that your Secretary attempts to frame your annual program. If in this next subject I were to select the one man I would want to address you, I would select the one who is to present the subject today, who happens to have his home in Milwaukee. It is most important that we have a broad understanding of our basic problems, and I think it is as important to have a social view of medicine from one so eminently qualified to give it to us as it is for the public to have a medical view of social medicine.

Dr. Lapp, author, compiler and publicist in the Social Sciences, was from 1908 to 1913, the legislative reference librarian of the state of Indiana. From 1918 to 1919 he was director of the Ohio Health and Old Age Health Insurance Commission. He was managing editor of Nation's Health from 1919 to 1923. He was director of the Social Action Department of the National Catholic Welfare Council from 1919 to 1927. He is head of the department of Social Science and professor of sociology of Marquette University. In the year 1926-27, he was president of the National Conference of Social Workers. It is a source of personal pleasure that Dr. Lapp is here and I present him to you at this time.

Dr. John A. Lapp: Mr. Chairman, Mr. President, Ladies and Gentlemen: Some years ago, my daughter, then five years of age, was asked on the playground if her father was a doctor. She said proudly, "Yes, he is a doctor." Then she began to think about midnight calls and the other things associated with a doctor and she said, "He is a doctor but not a real doctor." (Laughter)

I have always been impressed, at least for the fifteen years or so that I have been interested in the problem you are discussing today, with the great romance of modern medicine. That romance is not talked about enough. It is not written about enough. We hear about the improvements of health, but we seldom do visualize the tremendous changes that have taken place under our eyes.

Last year in the United States there were a million people who did not die who would have died had it not been for the improvements which have taken place since I was born. Last year in the United States there were 250,000 infants under one year of age who did not die but who would have died if nothing had been done in the way of improvement since 1910. During that time, imimprovements have taken place so that 250,000 infants were saved. That is the record now for every year and as years go by the number saved will probably increase. Last year in the United States there were 2,000,000 people not seriously ill who would have been ill under the conditions of forty years ago. That is the romance about which we should hear.

Who is responsible for all of that improvement? It would be difficult to say. It must be divided among the medical profession, the advanced standards of medical practice in

* Presented before Secretaries' Conference, Milwaukee, March, 1931.

A Postgraduate Course in Nose and Throat Is Offered to Wisconsin Specialists, June 22—26

The State Medical Society announces that, if sufficient enrollments are forthcoming by June 13, a one-week postgraduate course for eye, ear, nose and throat specialists of Wisconsin will be given in the state by Dr. Franz Hasslinger, of the Hajek Clinic, Vienna. The instruction will be confined to the nose and throat, with particular emphasis upon the larynx.

If the acceptances are found to warrant the undertaking, the course will be held in Madison, at the Wisconsin General Hospital, from June 22 to 26, inclusive, during which five-day period the class will receive intensive instruction in approximately five hours of didactic instruction daily. The class will be limited to twenty members.

Dr. Hasslinger's coming to Wisconsin was arranged, on the conditional basis mentioned, through the cooperation of the State Medical Society, the University of Wisconsin Medical School, and the University Extension Division, acting through the Medical Extension Advisory Committee, as follows: For the Medical Society, Dr. O. A. Fiedler, Sheboygan; Dr. G. Gundersen, La Crosse; Dr. J. F. Wilkinson, Oconomowoc; Dr. M. D. Bird, Marinette; Dr. Karl H. Doege, Marshfield; J. G. Crownhart, Madison; for the Medical School, Dean C. R. Bardeen, Dr. R. C. Buerki, Dr. J. S. Evans; for the University Extension Division, Dean Chester D. Snell.

Concluding the 1931 medical extension series promoted by the three agencies mentioned, such a class will meet a demand frequently expressed by men in the eye, ear, nose and throat field for a high grade extension course devoted to their specialty.

Dr. Hasslinger is no stranger to Americans in this branch of medicine. Upon a similar teaching tour in 1929 he commanded the enthusiastic interest of many American groups. At present he is concluding a highly successful teaching itinerary which began last March. During these two American visits he has conducted classes in such centers as Wichita, Lawrence, Kansas City, Denver, Des Moines, Omaha, Milwaukee, Minneapolis, St. Louis, Dallas, Memphis, Cincinnati, New York, Los Angeles, San Francisco, Portland, and Seattle. Through the activity of several Wisconsin specialists who are familiar with his high reputation and ability as a teacher, it was possible to secure him for a course in Wisconsin just before his scheduled return to Vienna in July.

A letter to Dean Chester D. Snell from the University Extension Division in Kansas, where Dr. Hasslinger first held classes in 1929, told of the insistence of members for his return this year, and mentioned among his qualifications "his teaching ability, his command of English, and the most unique technique which he had devised for presenting a clinical course on the larynx." Assurance was given that by reason of his exceptional technique in teaching the anatomy and pathology of the larynx, through didactic lectures, clinics, and demonstrations, his class will receive a training in these subjects practically identical with that offered in Vienna. It is that work, with his technique in bronchoscopy and his development of the bronchoscope, which is the basis of his international recognition.

Dr. Hasslinger is carrying with him some sixty to eighty cylinders, each the exact reproduction of a certain pathological condition of the larynx, showing the most interesting cases which have been presented at the Hajek Clinic in a period of over six years. All specimens are examined through the phantoms under conditions that closely simulate those of a living patient. Having spent ten years in developing models and phantoms for the teaching of this work, he finds it possible to cover the field as thoroughly as was done in a four years' course only a few years ago. By use of the phantoms, each doctor enrolling may perform enough operations under Dr. Hasslinger's supervision to acquire some dexterity in the use of these special instruments.

This postgraduate course is not offered for training additional specialists but is to assist those already specializing in this field. Because of the individual attention given to each member, the class must be strictly limited, and since only twenty men can be accommodated, enrollments of that number will be accepted in the order received. The fee is $50—one-half payable upon enrollment and the balance at the time of the first class. Detailed information may be had upon inquiry to the University Extension Division, Madison.

the past twenty-five years, the medical research going on everywhere, the developments of public health measures, and other socialized means. It would be impossible to say just what percentage of the improvement has been due to each, but they all share in this very remarkable progress.

But in spite of all we have done we have not yet reached all of our people with medical service. It was interesting, a moment ago, to hear Dr. Harper say that seventy per cent of our people were not adequately served. We know that today there are hundreds of thousands of people relying upon chiropractors, and various forms of cults. We know that millions and millions of people are dependent upon patent medicines and self medication in communities which are considered to be more or less intelligent. I think the figures mount to half a billion dollars which we still spend for patent medicines in the United States, the best evidence in the world that we have not yet reached all the people with the knowledge of the benefits of medical service of the kind that organized medicine now gives. So we have much ahead of us to be accomplished.

SOCIAL MEDICINE

Coming to the subject of this address I would define social medicine, not as state medicine, nor would I define it with any single term. To me, social medicine is any kind of medicine that will bring medical service to all the people within their capacity to pay. If you can do that, with organized medicine as it is today; if you can do it with slight changes in the system that we now have, if you can do it by a combination of what we have today and the development of industrial medicine, health insurance and state medicine, I care not, so long as every person in this land is able to share in the benefits which the medical profession is in a position to give. With that view of socialized medicine, I think every one will agree, inside and outside of the profession. But with the methods of bringing that system about, there will be some disagreement undoubtedly.

The problem is perfectly clear. It is not one of the cost of medicine. The cost of medicine is not a real factor in providing medical service for the masses of the people of this country, despite the two or three million dollars that the Committee on the Cost of Medical Care is spending to find out the facts. It does not make any difference how much medical service costs. However much it costs, it is worth it. It is worth many times the cost of medical service last year that one million people did not die, and that 250,000 babies did not die.

Moreover, the total cost of medical care is really inconsequential when viewed socially for the masses of people. Furthermore, let me say, and I am quite sure you will agree with me, that the cost of medical care cannot be very materially reduced. When anybody proposes the idea that some way or other, by some hocus-pocus, the costs are going to be reduced, I think always in the terms of advancement of medical science; the new requirements for education; the new requirements for equipment; the vast institutions we must have in the form of hospitals and the investment in technical equipment we must find therein. I believe the cost of medical care is going to increase despite all the movements that organized medicine can make. The cost of medical care is going to increase, and as a matter of fact I hope we shall spend twice as much for medical care as we do now. We will spend twice as much for medical care when all the people of this land have the kind of medical service they ought to have within their capacity to pay.

DISTRIBUTION OF COSTS

Gentlemen, the people who are talking about the cost of medical care are barking up the wrong tree. It is not the cost of medical care. It is the distribution of the cost of medical care. It is not the aggregate cost of medicine that troubles us socially. It is the fact that the cost of medical care falls upon people unevenly, falls upon the weaker portion of the population and falls upon them when they are least able to pay the bills.

I do not need to do more than give you the figures of the way sickness falls upon us to show you how necessary it is to consider the question of distribution rather than the cost of medical care. Only about twenty per cent of us are seriously sick in any given year.

Eighty per cent of us escape serious sickness; that is, sickness lasting for more than six or seven days. It is a pretty hopeful thing, therefore, that eighty per cent of the people escape any disabling sickness of the kind likely to handicap them physically or economically in the course of any one year. Twenty per cent bear practically the entire burden of the curative work of medicine in this country. When you put the whole burden on twenty per cent, you realize at once it becomes pretty heavy upon each.

But that is not the real problem of distribution. The problem is really that the bulk of that twenty per cent is borne by a comparatively small number of people who are ill for a considerable length of time.

Some studies in connection with health insurance were made some years ago, through the co-operation of the Pennsylvania, Ohio and Illinois Commissions, which were studying the subject. It was found that of the twenty per cent of the workers who were sick, sixty-five per cent were sick for less than thirty days. That some nineteen per cent were sick for thirty days to sixty days. That seven per cent were sick from sixty days to ninety days. Six per cent of the workers were sick ninety days to six months. Three per cent were sick for more than six months, and about one and one-half per cent were sick for a whole year or more. If you had that charted on the board for you, you would see how necessary it is that for all those people the burden of sickness be distributed. If distributed, it would not cost each person very much, but when allowed to fall upon the comparatively few people who are sick for period of thirty or ninety days to six months or a year, it becomes a crushing blow to each.

We are altogether misled, I think, on this question of distribution, because we think there are three classes of people, the poor, the middle class, and the rich. As the statement has been made hundreds of times, the poor get all the medical service they need. The rich can buy all the medical service they need, but it is the great middle class that does not get the medical service it needs. It is a mistake to classify people from this point of view in respect to the poor, the middle class, and the rich.

Gentlemen, I am poor, I am a charity case if the sickness which happens to afflict me becomes the sickness that is going to last a year or two years, requiring continuous medical and surgical attention. I am a charity case under those circumstances and every other man in similar circumstances is likewise a charity case, because I cannot buy the kind of medical service I need within my income, even though it is sufficient for any normal happening. So you have, you see, not the poor, the middle class, and the rich. You have the people who must have some distribution of their medical burden all the way up from the poor to the fairly well-to-do classes of society. There are very few people who can stand economically the continued burden of a year or two years recurrent sickness with all the costs that go with it.

Certainly the doctors of this country are not making too much money. Certainly the hospitals cannot be run for less than they are being run. It is because we allow the burden of sickness and sickness costs to fall upon a very few people, and, again, to repeat, upon those people when they are least able to stand it. The burden comes back upon you, the physician, or the public because all people must be cared for in sickness.

The distribution by days of sickness is very uneven, running all the way from seven day sickness up to six months or a year. So also is the cost of medical care distributed in about the same proportion. The people sick for less than seven days do not have serious trouble, do not have to approach the charitable agencies. They do not, as a rule, have to ask the physician to give medical charity. But when we get beyond the seven days,—when we get up to thirty, sixty or ninety days, the cost gets beyond the ability to pay. The loss of wages and the cost of medical care, if distributed over the whole people, would be, after all, comparatively a light one. The total loss of wages for all workers in this country would be about thirty dollars a year in normal, prosperous times. At the present time, with the reduced scales of wages, the actual loss of wages on the

average would be not more than twenty to twenty-five dollars a year. The cost of medical care, if distributed evenly all over the United States, would be about the same, from twenty to twenty-five dollars per worker if it were distributed evenly and paid for on the basis of the present method of medical practice.

Assuming that the medical profession remain as it is, a total cost of not over forty to fifty dollars a year, distributed over all the people of the country, would provide for wages lost and all of the cost of medical service. If we allowed two-thirds approximately of the cost, the amount would be much less than that. At the present time, from thirty to forty dollars a year would probably take care of the burden of sickness and distribute it upon all of the workers.

AGAINST STATE MEDICINE

How bring about the accomplishment of that idea? It is not necessary to have the extremes of state medicine. I believe in a great extent of government development. I believe in an extension of public ownership of many things, but I see no reason why the state should adopt state medicine, so-called, in order to bring about the ideal of distribution I have been talking about. In fact, I do not think state medicine would bring that ideal.

It is conceivable that we could have a publice medical profession as we have a public school profession, as we have a soldiery, as we have generals in our army and admirals in our navy, and all of the officers down the line, but it is not likely such a system of public medicine would work out any too successfully. Believing as I do in the socialization of many things, I do not believe in the socialization of the medical profession to the extent of putting all of the work of medical care in the hands of federal or state departments or county or city department. Nor do I think it is necessary to do that to bring about what we have in mind. But it is necessary in some way or other to get the economic resources to pay the doctors from some one other than the man actually physically incapacitated and down and out because of the economic burden thrown upon him. He cannot pay the cost. The money must come from an organized plan with the industries or the community to pay the bills. There is no reason why the medical profession under a plan of social medicine should not practice just exactly as it practices today. It would only be a question of where the money comes from to pay them. If it comes from an industrial group or from the public treasury, it would be effective, in my judgment, as long as it did not make the medical profession mere servants of the state or of the county or city. We have had fairly good proof of the effectiveness of social medicine in the workmen's compensation law.

THE COMPENSATION ACT

If I were to be an advisor to the medical profession, I would suggest that physicians use their resources and efforts to make the workmen's compensation law, on the medical side, just as effective as it can be made in the interest of better medicine and surgery, as well as of service to the workers. When you have worked out the problem of the workmen's compensation in that respect, you have worked out the problem also of handling sickness.

We went through the same kind of difficulties in connection with accidents that we are now going through with respect to sickness. When the workmen's compensation law was proposed, the doctors did not realize the significance of workmen's compensation to them. I remember on the first occasion when a workmen's compensation law was pending in the state of Indiana, being very much surprised when it was suggested that the physicians ought to be consulted. I said to myself, "What interest has the physician in the workmen's compensation bill?" That was as unintelligent as I was at that time. I thought, "Why should they be interested?" They were not interested, generally speaking. I do not know about the history in Wisconsin.

So the first provisions for medical service under the workmen's compensation laws were pretty crude. In some cases the law provided that medical service should not be given more than two weeks; sometimes that there should not be more than fifty dollars paid in

a given case, sometimes the entire amount was limited to $200. When laws were passed at first there was fear that if adequate medical service were permitted it would bankrupt the insurance companies. But the physicians and social work leaders throughout the country began to bring their influence to bear and the medical service was enlarged.

The first state to put a provision in the law that medical and surgical and hospital service should be given no matter how much it cost was ridiculed. It was believed that no state could do it. But every progressive state in the union, practically, since that time has gone on adding more and more until now most of the leading states require the entire surgical, medical, hospital, nursing, and every other kind of care, and the insurance companies have not been bankrupt by it.

Again I repeat while the medical profession has not had the best of the deal in many of the states under the workmen's compensation laws, there is no reason why workmen's compensation laws in this state and every state I know anything about, should not be developed so as to establish the ideals of the medical profession in giving adequate service with the individual's choice of physician and without any hampering influences other than those which might be reasonably necessary in order that so large a scheme would be protected against the occasional persons who might take advantage of it. We have a perfect working system so far as human devices have been able to work it out and if it is not perfect, I think it can be perfected by greater intelligence on the part of the medical profession.

We have provided that every workman, no matter what his status, whether he be a worker getting twenty dollars a week or whether he be a worker getting forty dollars a week, whether he be what would be a charity patient or whether he be a patient who could pay for the service to a certain extent, shall get the kind of medical and surgical service he ought to have. If the law is reasonably well administered, no worker need worry that he is going to be thrown into poverty through a work accident. If it is not that way, it can be made that way. I know it is being made to work that way in many of the states.

Socialized medicine means to me, then, that men get the kind of medical service and the amount of medical service, and all the medical service there is available, not only in their own community, but in the state or anywhere without any reference to his ability to pay.

Gentlemen, in order that the workmen's compensation law may be ideal, there should be adequate provision that if in the man's community the facilities are not available for the kind of surgical service that man needs, the resources of the state, medically speaking, ought to be brought to him, for it is the ideal of medical service, under such a plan, to see that the fullest possible extent of medical service be provided in each individual case.

IDEA OF SOCIAL MEDICINE

The idea of social medicine is to extend the idea of adequate service to perfection in the workmen's compensation laws and to devise some plan by which the same system can be applied to the workers who are sick. There are a few standards I would like to lay down in respect to such plans. First, I would place adequate service, and I mean adequate service. I mean the fullest possible care that the medical resources of the state or county can afford. I believe that under any such plan there would not be a development of state medicine. I believe there ought to be such a provision in any plan whether it be industrial medicine or whether it be group medicine, or whether it be any kind of organized arrangement, that the individual shall have some choice, and a practically free choice of the physician who is to treat him, within certain reasonable limits.

Next, I would want to lay down the proposition that any kind of plan should be safeguarded so as to encourage the growth of preventive medicine. I am quite certain that we cannot have a successful growth of preventive medicine on a strictly fee basis. If physicians are to give preventive treatment and those preventive treatments are to meet the needs of the masses of people, somehow or other the economic side would

need to be provided for. I do not think it would be objectionable if the preventive side were arranged by the physicians in some group whereby the people paid annually for medical examination and for similar services.

I would want to be sure that any plan worked out would advance scientific medicine. Any plan ought to be defeated that would set back or hinder the development of scientific medicine. If public health arrangements and state medicine would deaden the physicians so that they would not have any incentive to go on with further study of medicine or the development of scientific medicine, that in itself would be sufficient to destroy it as a means of meeting the social problem that arises from sickness.

I have no patent solution to offer. As an outsider thinking in terms of providing the great boon of medical service to the masses of people, I am concerned with getting the economic resources that can pay the medical profession for the best kind of medical service it can give. If we, on the outside, can provide the economic resources, I think we can depend upon the physician to give the service.

Under a properly developed plan of socialized medicine we would have two groups of people; on one side the medical profession with the scientific means of providing, and on the other the people with the economic resources, able to pay for service rendered. Maybe the plan could be worked out on some sort of arrangement by which groups of doctors on one side would take care of groups of people on the other side. I have no plan at the present time, in that respect. I am interested in emphasizing the fact that sickness is a destroying force socially; that it provides us with most of our poverty, certainly fifty per cent of all the poverty of the land. I am interested in seeing the development of means by which poverty can be prevented to the degree possible when medical care can be brought to the folks who need it at the time they need it most and in proportion as they need it.

As to the future, I have no predictions. I think we are going to have a great extension of medical service to the masses of men. I think, too, we are not going to see any such disorganization of the medical profession as some of the alarmists are making us believe. I am afraid sometimes that the doctors are over-alarmed when they hear of the possible dangers to the medical profession. No plan of social medicine, whether it be of the kind I have described or any other kind that is likely to be devised will result in harmful effects to the medical profession.

You gentlemen here are interested in the extension of the best of medical service to every man, woman, and child to whom it is extended. I think it is a vital necessity to any kind of plan for the extension of medical service by social means that the arrangement shall take due care to see that the medical profession is so safeguarded that those things the medical profession has built up by constant effort and scientific development shall be preserved. And I think that can be done. If the medical profession is to be sacrificed, we had better stumble along with the burdens of the present, but I do not believe it is necessary to do either. (Applause.)

DISCUSSION

Dr. Otho Fiedler (Sheboygan): I am very much interested in what Professor Lapp has had to say to us. He has presented the case most ably, and I am convinced from the reading of much of the current literature dealing with the subject, that he voices the sentiments and thoughts of thousands of thinking men and women of our country. They would not have been able to express themselves as Professor Lapp has done, but they are certainly in agreement with his philosophies and conclusions.

No one who has followed the course of modern social developments in Europe and for that matter in many other countries of the world, but must realize that here in America we are the last nation to put into effect many social economic measures looking to the economic assurance of our lower bracket of income classes. This is probably because we have had a high standard of living and because of high wages a larger buying power than people of the same classes of the other countries.

The fact remains, however, that the greater majority of even our own people are in rather a constant state of fear, anxiety or worry over the prospect of a rather dubious economic future; fear that they may find themselves, or that they may leave their families in need of the necessities of life. What are the fundamentals of such a fear? On what is it based? 1. An old age in which one can not find employment. 2. Premature death leaving a dependent family. 3. Accidents causing either death or in-

validity. 4. Unemployment. 5. Maternity causing loss of time for the mother in employment. 6. Illness and premature death from diseases.

We have provided against certain of these contingencies in our Old Age Pensions and Mothers' Pensions, and in some states by invalidity insurance. Perhaps the most important factor of all is illness and premature death due to illness, and while certain industries have made provision to take care of those suffering under these handicaps, the state and society at large have taken no cognizance.

The Committee on the Cost of Medical Care assumes that the average cost of illness per family amounts to about $150 a year. To those whose income is less than $2,000 a year this is a greater burden than they can possibly meet unless they assume a standard of living below that which the Department of Labor considers as the minimum. It is possible that this burden could be assumed if the distribution were constant and regular or the distribution was over a longer period of time, but as the matter now stands when the blow falls, the cost of illness and disability may easily mount to sums that are entirely outside of the capacity of the individual to pay.

Dr. Olin West says that the most important problem before the medical profession today is to make available the best of scientific diagnosis and treatment to all the people at a price which they can meet. I agree with him and feel that this can not be accomplished under the present system of medical practice. Judging from what has taken place in Europe and what is now taking place on this continent in Canada, we have every reason to believe that before long the practice of medicine will be socialized in the United States. In fact, it is now placed by the American Federation of Labor as the first legislative item on their program, and already there have been introduced in certain states of the Union bills which will provide for socialized medical service.

As practitioners of medicine we are particularly interested that when this movement comes it shall be directed by the medical profession rather than by the politician to the end that certain fundamental relationships or conditions shall not be disturbed. We should strive to secure freedom of the people to select their own medical advisors in an attempt to maintain such relations as now exist between the doctor and his patient. On the other hand, we are concerned that the economic position of the physician shall not be jeopardized as may easily occur, but that the remuneration for medical services shall be adequate and sufficient to draw into this field of service, as it has in the past, some of the best minds of the period.

The Iowa system of treating indigents through the county organization is really a movement in the socialization of medicine for this class. I can easily see that an extension of the idea to those in the next higher brackets of income would be quite justified and easily arranged on a basis of their contribution to a common fund possibly augumented by a subsidy from either the county or the state.

At any rate, I feel rather assured that the present economic status in the practice of medicine is not permanent and that within comparatively few years we will be called upon to meet a new situation. How we shall meet it and what its effect upon the medica profession shall be will be determined in a large measure by how well we have studied the problem and how efficient a system we have evolved.

Medical Care for the Indigent; A Symposium*

By F. M. WYLIE
Deputy Attorney General
State of Wisconsin
Madison
and
VERNON D. BLANK
Managing Director
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Mr. Wylie: It is told of Henry Ford that when his corporation first installed a legal department within its own organization, he one day visited the new department. He gazed about the book-lined walls in amazement, and asked: "What is this, a library? What are all the books?" When told that they were law books, he exclaimed in disgust: "Law books? Law books? Well, get 'em out of here! I hired you to know the law."

I am just a little afraid that is too much the popular impression of a lawyer, while, as matter of fact, Abie the Agent was probably nearest the truth when he said his lawyer did not know any law but he knew what page it was on.

I am exceedingly diffident in discussing the subject of poor relief before you men who undoubtedly know a great deal more about it than I do, for after all, law in its application depends more upon facts than upon legal rules. Many more mistakes are made by lawyers, off and on the bench, because of wrong information or a wrong view of the facts, than from ignorance of the law.

Now, you gentlemen pretty well know your facts on this poor relief proposition. I perhaps know a few statutory provisions and rules of law that fit in. So maybe after all, if we get together, neither

* Presented before Secretaries' Conference, Milwaukee, March, 1931.

of us thinking we know it all, or that we know it all between us, we may arrive somewhere.

The poor we have always had with us, and so poor relief laws are founded in a great antiquity, and some of them belong only in an antique shop; they are just poor laws, not poor relief laws. That is probably due to some extent to certain characteristics of minor,—and not so minor,—public officials, to be technical and parsimonious with poor relief funds; like blind leaders of the blind, they are poor relievers of the poor. And it is maybe due in some measure, on the medical end of poor relief, to an easy-going attitude among physicians.

Now, until a few years ago, in counties retaining the town system of poor relief, that is, the system where the separate towns, villages, and cities care for their own poor, instead of the county taking charge of the matter, the entire town or village board, meeting and acting as such, had to authorize a doctor to attend a poor person, and if the authorization did not precede the attendance, the doctor could not be paid. This was surely a poor system, for a ruptured appendix, for instance; and while no doubt in innumerable instances the local boards were sensible about it, yet many were not, and were ready to take advantage of a lack of prior formal authorization. It is still the law that there must be a prior authorization, but in 1927, at the instance of the State Medical Society, some simplification was secured by the provision that the town chairman or village president may order emergency relief; or the board can designate some other person for that purpose. That has helped some, just how much, you gentlemen know better than I do.

Another prevalent error in poor relief is the rather common impression that if a man has any property or any income, he may not receive public aid. Even one of the judges of the Supreme Court took this view not so long ago, but the balance of the court did not agree with him, and held that "needy" actually means what it says, in need—not necessarily destitute, but merely a lack of present means to provide all of life's necessities. Probably the mother's pension law has done something to increase this misconstruction of the law by local poor officials, or poor local officials, for that law has different requirements than has the general poor relief law. Medical relief may be furnished under the mother's pension law, or if the mother is not receiving a mother's pension, under the general poor law. But to get back to this mistaken idea that a man and his family must be left to starve or die of disease if he has frozen assets (that is quite a prevalent disease nowadays) or may not receive medicines or a doctor's care if he has sufficient income to pay for the means of subsistence in health,—so commonly is this used, in ignorance or in parsimony, to deny essential care, that no doubt some well-meaning people have had introduced a bill to add to the law the clause: "The ownership of a home or an equity therein shall not bar the granting of relief to any person who by reason of unemployment or sickness stands in need of such relief." Now this may be intended to reach only those cases where the owner would be able to raise a little money on the home and be meant merely to protect the home (which, by the way, is not exempt from the claim of a town or county for poor relief expenditures) but the bill does not so say. And were such a bill enacted, it probably would narrow the law rather than broaden it, the rule of construction being that it being expressly provided that ownership of this certain property should not prevent relief in these certain contingencies, relief would be excluded in all other contingencies and upon ownership of any different property. And so it goes with the poor laws, a tinker here and a damn there, until some of them are hardly worth a tinker's damn.

MANDATORY DUTY

One thing it is well to know, and that is that under the law the giving of poor aid to a needy person is the mandatory duty of the proper officials. Of course, if they won't, they won't, and how is a poor devil who cannot buy a loaf of bread or a box of pills going to get his rights? But the refusal is more often, I think, because local officials think they have a discretion in the matter. And when it comes to needed medical care, I think it would be well if the physicians would more often disregard their natural reticence to insist upon more employment of themselves, and advise officials of their legal duty to furnish it.

Altogether, though, there probably is no getting away from tight local officials and an arbitrariness in disallowing and reducing physicians' bills, whatever the remodelling of the law, or the educational insistence of physicians that the sick poor be not neglected. The condition may be improved somewhat, but it cannot be cured. I think the prognosis is "not so good."

I do believe, however, that by concerted action, and by lump sum annual contracts, the amount based upon experience, a great many of the evils of present conditions may be eliminated.

Now, county medical societies in Wisconsin are corporations. A corporation may not practice medicine. By the better authority, furnishing medical aid by corporation employed physicians, is the practice of medicine. Mayhap, the furnishing of physicians by a county medical society, there being absent many of the objectionable impersonal and commercial elements attached to a strictly private business corporation, might be passed by the courts. But corporation practice is not to be desired, it is subversive of the essence of professionalism, and so why provide the opening wedge yourselves.

All the advantages of corporate contract, may, I believe, be secured by group contracts, without the objectionable corporate features. I readily admit that this belief is not the result of experience, or even of experiment. I have assisted in the draft-

ing of one or two of these contracts, but only recently, and I have no knowledge of actual results.

I readily admit, also, that many practical difficulties are to be met in effecting and carrying out such an arrangement. Many local poor officials are exceedingly touchy, and physicians, by and large, are not altogether devoid of temperament. And then the poor are a particular object of attention from public welfare neurasthenics, well meaning, but more or less paranoiac.

I will leave the practical problem to you,—just another disease for your diagnosis and treatment, a sort of social disease,—and I will content myself with suggesting one or two specifics, to be prescribed by you, with discretion.

Most important legally, is to avoid a general liability by all the group, for the malpractice of any particular member. Probably this is important practically, too, although it would tend to inspire public confidence in the profession if the group were willing to vouch for one another to that extent. But it would present many difficulties in litigation, and might even be hailed as another evidence of the mythical "medical trust," and we have not yet reached that stage of professional brotherhood, mutual confidence, or personal affluence where we are ready to pay for the other's fault. I can see where insurance, if the physicians could get a satisfactory insurance service, might eliminate some of the drawbacks, but not all of them. So it is important, in planning any medical group poor relief, to protect against any but individual liability, each for his own case. Happily, this is not at all difficult. Just do it the simplest way, expressly, definitely, in so many plain, English words in the contract.

Another thing to take care about in group contracts for poor relief is to confine the scope of the contract to the scope of the poor relief laws. Unfortunately the laws are vague in their language in many particulars, although the more important of these have been interpreted and made clear in court decisions. But you still have to be a lawyer to know what can be done and what cannot be done under the poor laws, and I do not guarantee that the lawyer can always tell. It is wise, therefore, to use the language of the statutes so far as possible in the contract, and to refer to the statutes rather than to attempt to restate it.

In the time that I have, I cannot discuss in more detail the relation of the physician to poor relief, but it is an important, although unprofitable department of your public relations, and I believe by concerted group action you may not only eliminate some of the unprofitableness, but also some of the friction that has its part in prejudicing an uninformed and misinformed public.

I just want to leave with you the warning not to hope that any law or any plan will entirely relieve you of "the physician's burden"—charity treatment of the poor.

Chairman Sexton: We have all watched the work done in Iowa with a great deal of interest, and I think we are fortunate in having the Managing Director of the Iowa Society here to tell us what that plan is.

The Iowa Plan

Mr. Vernon Blank (Des Moines, Iowa): We should, of course, acknowledge our indebtedness to Wisconsin for some of the things in which we are engaged in Iowa before we tell of the things in which we are plunging ahead. In connection with the whole matter of speakers and programs, we got our inspiration from what you have been doing here the last few years; and only last fall we organized in Iowa a Speakers' Bureau. Iowa has a very active committee membership, an exceptionally strong chairman, and a young lady who is a full time executive secretary for that body.

This matter of caring for the indigent sick has very intimate connections with several of the fundamental problems of medical practice today, and before closing I should like to refer briefly to the connection between this particular activity and the tendency toward state medicine. First, I want to describe as briefly as possible what is referred to as the "Iowa plan." Last November, at the time of the State Secretaries' Conference in Chicago, Dr. Parker, Secretary of the Iowa State Medical Society, explained this plan. Since then, we have corresponded with the various state and county societies over the United States, and a number of counties have adopted the plan.

The county medical society, frequently incorporated, but not necessarily, enters into a contract with the county authorities to render, as a society, all care to the indigent persons for a year, for a fixed annual sum. Of course, the details of these contracts vary greatly. In some cases, they give every possible service, including surgery, and serve the county jail and county poor farm. In other places, all these miscellaneous things are excluded and serums and antitoxins are not given except on fee. But that is a local problem. The general purpose is to relieve the county supervisors of that difficult task of dealing with detailed bills and items for service, the value of which they know nothing, and which often lead to considerable difficulty and misunderstanding between the medical profession and the board of supervisors. As far as the county society is concerned, it generally remedies a situation becoming increasingly annoying to the physicians of America.

We found it true in at least half of the counties of Iowa that the physicians were expected to render more or less gratuitous service to county paupers. It was due to two reasons. The code of ethics is interpreted by the average layman to mean the doctor always renders the service and does it free whenever there is any difficulty in collecting the bill. The other reason was that the medical profession has been extraordinarily unbusinesslike in

dealing with the state and county agencies. There is not the slightest reason in the world for the medical profession to be unbusinesslike in dealing with the county board of supervisors because when any other service or commodity is delivered to these county paupers, whether it is coal or clothing or rent or groceries, it is paid for in cash generally without any discount whatsoever. There is no reason why medical service should not be paid for the same way. It should be the more so because medical service is ordinarily the basic service to be rendered in such cases. Practically all borderline pauper services are of the medical type. For instance, a man might break his leg. If he is given immediate, proper care, and placed back on the payroll as soon as possible, they may keep him off the county list for the winter. So the borderline case is ordinarily medical, and the skill and efficiency of medical service is very often the determining factor as to whether or not the county is going to have to spend other moneys over a long period of time for groceries and rent.

I do not know what the Wisconsin law is in connection with requiring payments for services, but in Iowa we discovered that the provisions of the code were such that in any case where medical services had been properly authorized either by the township trustees, the overseer of the poor, or a member of the county board of supervisors, the physicians rendering those services had every legal right to collect a full fee. The Iowa law reads that the physician shall receive no more than is ordinarily paid for such services in that community, which means he can receive the regular fee that would be charged to such an individual in that community and can go to court and get it. There have been several cases in the Supreme Court in Iowa in the last twenty-five years on that point and the decisions have been the same,—that the physicians could collect.

In Muscatine, we discovered a year ago there was no record that any member of the county medical society had ever received any money from the supervisors of that county for medical services, and the membership of the society extended back over thirty years. The Board of Supervisors in that county had never paid a red cent for medical services. That situation has been remedied, because the Muscatine Medical Society, last month, made a contract with the board of supervisors for the care of the indigent sick.

Unity is the first achievement, for you cannot have a county contract unless there is unity which has far-reaching results. The reason for our becoming interested in the matter of county contracts was from trying to ascertain why certain county societies were so extraordinarily efficient and so united and effective when it came to scientific programs, or anything else the society was called upon to do. There were certain outstanding organizations always alive and doing effective work in any field which they chose to go into. Most of those societies had county contracts. One contract has been in effect in Iowa for twenty-six years. Another starts its twenty-first year next month. They have operated successfully and harmoniously all that time.

You have in your hands a chart which shows not only the length of life of these different contracts, but other details about the contracts themselves. Except for two of the societies which have such contracts in Iowa, this sum annually received from the county board of supervisors is not divided but left in the county society treasury, and used to pay all local expenses, which often mount high because when a society has plenty of money it has good programs. You will find the Waterloo Society listed among those which have contracts. It has been in force for over twenty years. Incidentally they have almost $30,000 in the treasury, and that organization has nine monthly meetings of a very high quality. If they want a man from Philadelphia or Boston or San Francisco, they have him. They pay for all the dinners, including guests from surrounding counties. They pay the county and state dues and the A. M. A. fellowship out of the general fund. In addition, several of the county societies are now contemplating group malpractice insurance to be paid for out of the lump sum received from the county.

ADVANTAGES

The advantages to the county society are: first, businesslike treatment at the hands of the supervisors. And I want to call to your attention the fact that that means more than just relief from the feeling of being unfairly treated. It means more than relief from the annoyance of making out and prosecuting the collection of various bills of different sizes and being humiliated by having your services depreciated and your bills cut in two and having disagreeable discussions with the board of supervisors. It means that the medical profession in making this agreement clearly and publicly places a definite value upon its own services, and demonstrates that it proposes to be treated in the same businesslike way as other groups in the community. There have been one or two critical remarks and editorial comments in certain localities when a contract was made, but that is the exception. There is no reason in the world why the medical profession should not be properly evaluated from a financial point of view.

In the second place, it produces a remarkable degree of unity, incidentally helpful in the esprit de corps of the organization, but particularly effective when the society has some common problem to work out.

In the third place, such a society is well financed. One of the societies is planning to build a little medical center of its own out of the accumulation of several years.

Finally, the society thus organized, acting as a unit, is ready to meet some of the oncoming problems of socialized professional practice.

Instead of referring to medical practice, as I have generally done before, I have referred to it as "professional practice," because yesterday afternoon

I was in the office of the attorney general of the state of Iowa. The State Bar Association has introduced in the state of Iowa a bill prohibiting the corporate practice of law. This attorney pointed out that the two professions had a very common interest in preventing the corporate practice of any profession. The Iowa Supreme Court last fall had a case of a dental clinic which was incorporated and owned by laymen in which it was decided they could not practice dentistry. Of course, you know some banks print schedules of fees for the legal services the bank renders through a salaried attorney. That is as objectionable as any form of state medicine. The two professions have a common problem which must be faced together.

MEETING OTHER PROBLEMS

It is our feeling that, when a county society becomes closely enough knit so it can act as a unit in making a contract with the county board of supervisors, then such society is ready to meet some of these new social problems coming along. It is ready to deal with the lay health agencies. It is also ready to deal with that borderline group of cases that does not come within the county pauper list but is still not able to pay a reasonable fee, which in the city has fallen into the care of private charity; has had discounted bills, or has had service rendered gratuitously by the physician, knowingly, at the time he rendered it. Such a society is ready to handle these borderline cases, and one or two societies with contracts are already working on this problem.

The idea that Past President Harris of the American Medical Association constantly held out was that state medicine could be avoided by the county societies becoming so well united they could act as a group in doing themselves the things which governmental, lay or business agencies may otherwise attempt to do. After all, the fatal defect in state medicine is not group or united action. The fatal defect in state medicine, the thing which makes it objectionable both to the professional man and the intelligent layman, is that the sacred personal relationship between the physician and his patient is interfered with by a third party, whether a corporation, a lay organization, or some state agency. That relationship is not broken when the county society, upon the guild basis, acts as a unit, as a self-determining factor, and does what the majority of the members of that organization want to do.

Now I come to the last thing and that is a caution. I have, for any one who wishes a copy of it, Dr. Parker's complete paper discussing the subject. We have had to amend the statement we have previously been making, advising the county societies to incorporate for this purpose. Many boards of supervisors, and in most cases the county attorneys, desired the society to incorporate so one officer thereof could legally sign the contracts. From the viewpoint of the medical society, incorporation also seemed advisable because it limited the liability of members. If you enter into a partnership, each and every member would be liable in case of any malpractice suits arising under the contract, it might be embarrassing; so most of our societies are incorporated. But now we must change the procedure. In the past, all of the court decisions, up to last December, were to the effect that a corporation that had other than licensed practitioners in it could not practice any profession. Some twenty-five years ago, the Supreme Court of Nebraska decided that a corporation which consisted exclusively of licensed physicians could practice medicine because each and every member thereof was licensed.

Last December, the California Supreme Court disapproved that decision in a precisely similar case. A medical organization, incorporated, consisting exclusively of licensed physicians, was enjoined from the practice of medicine on the ground that a corporation could not practice a profession. That illustrates not a shift in position as much as it does shifting a legal opinion to conform with changing social conditions.

When I went over to our attorney general and asked if we could find some way to continue incorporated and yet not violate the law, he said, "The physicians of the United States are just as anxious not to have corporations, whether they are all physicians or not, practicing medicine, as the lawyers are anxious not to have corporate practice of law. And if you let the bars down even for a county medical society, incorporated, there is no telling how rapidly you may get into state medicine."

So we are going to unscramble our incorporated societies. Or at least the dealings between the society and the supervisors will not be through the incorporated society.

Fifteen out of the ninety-seven societies in Iowa have such contracts. Ten have been completed in the last few years, and those that have been completed since December, instead of having an incorporated society enter into the contract, have followed this plan. Where the society was under thirty in its membership, each individual member of the county society signed the contract. The larger societies will simply have the officers of the county society sign. That has not met with objection by the supervisors, so we have gotten along all right with the business end of the arrangement.

The objection was raised by some of the members, in connection with such plan, that they might have damages for malpractice coming back on them. We are solving that by making certain that each individual member of the society has a malpractice policy, the premium on which is fully paid up for the entire year of the contract. Two or three societies are now planning to go further than that and buy group malpractice policies, the premiums to be paid for out of the proceeds of the contract.

I understand that at least two county societies in Wisconsin are actively interested in this project, and we are hoping the discussion of the matter here may be of help. If there are any questions, I shall be glad to answer them. (Applause.)

Chairman Sexton: We certainly must have some discussion of this intensely vital problem which Mr. Blank has brought to us.

POLK COUNTY CONTRACT

Mr. George B. Larson (Frederic): Usually the poor people are indebted to the physician; but in Polk county the physicians are indebted to the poor. Were it not for our indigent poor we would not have the united, separate county medical society we have today.

First, however, I would like to circulate copies of the contract recently put into effect to cover the care of the indigent sick; for my talk will center around that for the most part.

In Polk county, for a long time, we have been thoroughly disgusted with every type of poor relief we have had. In casting around for some solution to the problem we came across Dr. Parker's paper which was published in the December issue of the American Medical Association Bulletin and devoted to the contract system of caring for the indigent sick. We are grateful to the Iowa State Medical Society for that plan. Almost every bill our members sent to the poor relief committee came back either cut in half or entirely disallowed. Finally, we called a meeting of all physicians in our county who were operating hospitals. This gathering developed into an indignation meeting. Almost all of the evening was devoted to the discussing—emphasis might be placed on the "cussing"—of our welfare worker. This common oppressor united us into a workable society.

I wrote Mr. Vernon Blank to secure detailed information on how the plan worked in Iowa, and how the system met with the approval of the physicians and the welfare workers. This information was brought before our county society. At first they were a little "leery" about taking up the project. They wanted to know more definitely how the Iowa societies had fared and how long they had used the system, before they would consider adopting the plan. After the details had been presented to them, however, they decided to adopt it. With the society accepting the idea, the next real task was to interest the Children's Code Committee, our poor relief committee. They were skeptical at first. We had to convince them that the plan had worked favorably from the standpoint of the welfare workers in Iowa. It was necessary to secure testimonials from a number of their welfare workers before they would consider the plan. Every answer I received was enthusiastically in favor of the system. Those testimonial letters proved to be our greatest selling point. After a little bartering we reached a mutually agreeable figure and contract.

The members of our society were anxious to incorporate. Naturally, they did not want their property liable should another member be sued for malpractice for an act performed under this contract. We felt that the contract we had drawn for this work should meet with the approval of our State Society, and consequently a copy of the contract was mailed to Mr. Crownhart for his consideration. Our contract was referred to the legal counsel. It was found to be illegal for a corporation to practice medicine in Wisconsin. We appealed to our State Society for some solution that would still retain all the good features of the Iowa Plan. The legal counsel prepared the contract which has been passed out to you. We adopted the contract virtually word for word.

I just want to enumerate for you the things which I feel are vital. First, and probably most important, is the opening paragraph. It distinctly points out that it is an individual contract, but also a collective contract. This evades the necessity of incorporation and still protects the members from malpractice suits arising from the deeds of another member. Paragraph one stipulates that only cases arising within the county and treated by members of the society are covered by this contract. You can realize what would happen if that clause were not there. If an indigent patient went from Polk county to Superior, for example, and became sick, the payment for fees would naturally come out of the sum paid to us. Perhaps the members of other medical societies would not be considerate of us in making their charges. As a result the money would be paid to men outside our society and our members would be caring for the resident poor without compensation. So, all cases of indigent sick not treated by us must be paid for by the poor committee out of their own fund. We have had one experience with it already, although the contract has been in effect only eight days. The patient was in the northern part of our county. The neighbors called in a Burnett county physician, not a member of our society, and asked him to care for the case. The town chairman in the locality called the welfare worker to secure authorization for the doctor on the case. The welfare worker informed him that they had already paid the Polk County Society for the care of all indigent cases, and that if she authorized that physician to take care of the case they would have to furnish the pay for it in addition to the sum paid our society. She told the town chairman that she would furnish them with a member from our society. She did call, which was a surprising thing for it was the first time in history that the welfare worker has called us. A member of the society was called to take care of the case. That is an example of how the welfare work must be taken care of by the society and how the society, in a measure, controls the health program of the Children's Code Committee.

The next important item is section eight, the problem of authorization. I think there has always been a laxity on the part of the medical profession when dealing with an indigent patient. We have developed a very definite system of authorization. Our contract states that emergency cases may be authorized by any member of the Children's Code Committee; but a chronic case, where they have time to

deliberate, must be authorized by the chairman of the committee. We have regular authorization slips which must be signed by the person authorizing the bill. The slips are arranged in triplicate. One copy is kept by the poor committee; one is sent to the doctor; and the other is sent to me as secretary of the society. We were fearful that, unless we had this system of authorization, differences would creep in and disrupt the unity of our society, which is worth many times the price we are being paid for the caring of indigent sick. We do not want our society split up by ill feelings among the members when dividing the money at the end of the year.

One of these authorization slips must accompany the member's bill before the society is obligated to pay for the services. As Mr. Blank said, the society has to be unified in order to carry on this type of work and after there is this unified spirit, it would be a shame to ruin the society through a lack of proper authorization.

Another important point in the contract, as developed by the legal counsel, is that it is not absolutely imperative that one particular member attend the indigent patient. If he refuses, or has a reason for not going, another member of the society can be called upon to take his place.

There is also a provision for the limit of fifteen miles. Our community is entirely rural. Should some indigent person demand the services of a physician living at a great distance from him, it would be a hardship on the member to travel a long distance to care for the patient. And, after all, the indigent person should not have too much choice about who attends him.

You will note in the contract that the society pays for x-ray photographs, x-ray treatments, surgical appliances, and small items for ambulatory patients. But on cases that are hospitalized the county pays for them. We have a particular reason for having that provision. The members of the society were afraid that unless they adopted the contract with this clause included, we might have welfare workers who would load every office with indigent patients. If the county realizes, when they take a patient in, they are going to have to pay for hospitalization in addition to the contract sum, they will bring only the patients that need the care.

POLK COUNTY MEDICAL SOCIETY CONTRACT FOR CARING FOR THE INDIGENT SICK

It is hereby agreed, by and between the County Children's Board of Polk County, hereinafter designated the party of the first part, and each of the other signers thereof, individually, but collectively designated parties of the second part;

1. Each party of the second part covenants and agrees to provide such medical and surgical care and treatment, excluding obstetrical cases, as may be required of him hereunder during the calendar year of the Children's Code Committee from November 1, 1930, to November 1, 1931, for county patients of Polk County, Wisconsin, arising within the county, and treated by the parties of the second part.

2. The parties of the second part shall maintain a central office or place of call where any of the officers authorized to order aid for county patients may place calls, in case the nearest physician is not available, and prompt response shall be made to all calls so placed. In emergency cases the call may be placed with any party of the second part.

3. The party of the first part may designate which party of the second part is to respond to a call, when the patient has so requested, and provided that the patient is not, at the time of requiring treatment, a greater distance than fifteen miles from the physician so selected. But when the physician so selected is for any reason unable to respond to the call, or is unwilling to treat the patient, another of the second parties shall be secured.

4. The party of the first part shall not be required to furnish or pay for transportation of any of the second part in the performance of this contract.

5. Second parties shall furnish all necessary x-ray photographs, x-ray treatment, laboratory work, surgical dressings, surgical supplies, and surgical appliances except limb or members or trusses, for all county patients, except hospital patients as hereinafter defined. First party shall pay for the expense of furnishing toxins, antitoxins, serums, quarantine bills, artificial limbs, members or trusses or lenses or frames for lenses. First party shall pay for the expense of furnishing hospital care, drugs, medicine, surgical dressings, surgical appliances, x-ray photographs, x-ray treatments, laboratory work and special nurses, necessary for any hospital patients.

6. First party shall pay the sum of $..... on or before one month from the date hereof, payment to be made at the central office specified in paragraph two hereof, payment to be in full consideration for the performance hereof by each party of the second part. First party shall not be under any obligation whatsoever with reference to the distribution of said amount among the second parties.

7. Payment for any supplies or things required by paragraph five hereof to be paid for by the party of the first part shall be made at the central office specified in paragraph two hereof, and shall be made within thirty days after the submission of a bill verified as bills against a county are required to be verified. In case the appropriation is depleted bills referred to in this paragraph are to be paid promptly after the regular meeting of the county board.

8. "County Patient" is hereby defined to be any resident of Polk County designated by any member of the first party as an indigent person within the meaning of Chapter 49 of the statutes. "Emergency" is hereby defined to mean emergency as used in chapter 19 of the statutes. Only a person authorized in manner provided by law to do so, which is any member of the County Children's Board may designate a case an emergency case. If in any case designated as an emergency case, upon investigation by the first party or any of the signers hereof, the patient is found not to be indigent, nothing in this contract shall prevent the party of the second part rendering any service to such patient from recovering therefor as from a private patient.

9. "Hospital Patient" is hereby defined to be a county patient requiring hospitalization, including county patients in hospitals as of the date hereof. No county patient shall be removed to any hospital, except in emergency cases, without an order from the chairman of the first party.

10. It is mutually agreed by all the parties hereto that this contract is a several contract by and between the first party and each of the second parties, and that the second parties are not bound jointly;

and that this contract is not made for the benefit of any county patient; and that the default, malfeasance, or misfeasance of any party of the second part shall not be attributable to any other party of the second part.

In witness whereof the parties hereto have hereunto set their hands at Dresser Junction, Wisconsin, this twentieth day of March, 1931.

For Polk County Children's Board.

.....
(signed) Mary B. Nelson

.....
(signed) Fred M. Nelson

For Polk County Medical Society:

.....
(signed) L. O. Simenstad, Pres.

.....
(signed) Geo. B. Larson, Sec.

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INSTRUCTIONS AND INFORMATION COVERING COUNTY-SOCIETY CONTRACT

Members Children's Code Committee:

Mr. Fred N. Nelson, Chairman, Dresser Junction.
Mrs. Ralph Corcy, Secretary, Osceola.
Mrs. A. N. Nelson, Clear Lake.
Mr. Edw. Swenson, Amery No. 3.
Mr. Jens Jensen, Luck.

Instructions:

1. No indigent maternity cases are to be paid by the Society. Indigent maternity cases are to be paid through the Sheppard-Towner Act. Petitions for maternity aid must be made out, signed and forwarded to Judge Lynn prior to the confinement. (The Board will, in some cases, grant aid if the petition is mailed immediately after the confinement.) Blanks to be used in petitioning for maternity aid may be secured either from the Secretary or from the County Judge's office.

2. All cases, to be paid by the Society, must be authorized by at least one member of the Children's Code Committee.

3. All bills submitted to the Society must be accompanied by a signed authorization slip. A copy of the order is sketched below.

4. Hospital authorization slip for emergency cases must be signed by one member of the committee; all other cases must be signed by the chairman of the Children's Code Committee, Mr. Fred N. Nelson, Dresser Junction.

5. Please mail your bills to the Secretary promptly after you have dismissed the case.

6. Mail all bills pending since November 1, 1930, to the Secretary on or before April 3, 1931. The Secretary will meet with the Children's Code Committee at that time and determine the validity of all bills prior to that date. Please give this your immediate attention.

Information:

Your particular attention is brought to paragraph five of the attached contract. You will notice that you are to submit your charges for x-rays, physiotherapy, etc., on non-hospital cases to the Society, while similar charges for hospitalized patients, coming under the contract, is to be made directly to the Children's Code Committee.

Authorization Slip:

Date.....

To Dr. .....
you are authorized to treat.....
..... for
.....
does

This authorization does not include authority for hospitalization at County expense.

Signed .....

We did not include obstetrical cases in our contract as they are taken care of in our county through Maternity Aid. They have been rather liberal in granting aid in connection with maternity cases, even though they have not been authorized prior to the time the services were rendered. They realize the people who call for that type of service never come in to see the doctor ahead of time, because they know he probably will ask them about the old bill.

WHO IS INDIGENT?

There is one thing on which I wish more emphasis would be placed. That is who is an indigent person and who is not. I have corresponded with Mr. Crownhart on that subject and I suppose we are as far from it now as we were before. The definition I have from the legal counsel of the State Society is "that a person is indigent who has not the money or income or property or credit or other means of providing the necessities of life." In a good many places, particularly in our community, it would mean that over half of our population would be among those classed as indigent persons. Of course, that would not work either, if it were taken literally. So we have gone down the scale a little and taken the people who are almost destitute. That is really our definition of an indigent person.

The last paragraph in our contract is more or less of an explanation of the opening paragraph. It is, that this is a group contract, but at the same time, an individual contract and that none of the members are responsible for the malpractice acts of any of the other members. I wrote to the Medical Protective Company and tried to secure group malpractice insurance but the letter I received in reply was a five page letter which made me feel thoroughly "sat on." They seemed to feel that I was asking for something unfair and unethical. They advised me to get a separate contract for each of the members, and if the society so wished, pay for it from our treasury.

Out of the money we received on our contract we are going to take about ten per cent to carry on the work of the society, such as programs, credit rating system and general expenses. The other ninety per cent will be divided among the members pro rata, according to the volume of work, at a predetermined fee schedule, arranged by the members of the society. There is a population of 26,000 in our county. Last year the county spent $3,017 for all medical care, drugs and hospitalization. We received a substantial increase over what was paid

last year, when we received $2,500 to cover medical and surgical care only. But, at the same time, every physician in our society is wondering what percentage of his full bill he will actually receive.

Mr. Blank made a statement which is true when he said that the societies grouped together under this system are more ready to take care of new problems because they are unified. They are unified because they do not have to ask for state dues, county dues, or special assessment. There is nothing that will kill a society quicker than asking for money. I know when our old five-county society was asked for a small increase in state dues they resented the idea. They did not believe they were getting their money's worth from the State Society. But when they became acquainted with the great work the State Society is doing it was a simple task to get the increase in dues. Perhaps Mr. Crownhart would not wish me to say anything further on this point for fear you may think he is going to ask for another raise in dues.

I think one of the greatest things for a county medical society is unity. The contract system of caring for the indigent sick is a means toward this unity.

GENERAL DISCUSSION

Chairman Sexton: Is there any one who wishes to ask further questions regarding Mr. Blank's address.

We have a peculiar situation at Marshfield, and I believe you must all find the same thing. Of course, we draw from a territory of probably forty or fifty miles, which includes patients from various counties. For a long time, we would take care of those patients, not knowing their financial condition. About the time they were to leave the hospital, we were surprised to find they had no funds at all. Then it was too late to get any action, and, as a result, we treated that patient without any compensation at all. Within the last two years, we have changed our policy regarding this. By co-operation with the hospital, we find whether these patients are able to pay their hospital bills the first week. I am speaking of hospital cases. If they are not able to pay their hospital bills the first week, then we begin an investigation to find why they cannot pay their hospital bills. If they cannot pay their hospital bills and are indigent patients, we charge this hospital care and treatment to the city of Marshfield. The city of Marshfield, in turn, charges it to the county, and the county transfers that charge to the county from which this man comes. That can be done easily if you have the co-operation of the poor committee and the poor committee realizes it is not a charge against the city or county in which the physician resides, but that they can take care of those patients who come from other counties, charging back the costs to the county of residence. I think possibly that is not understood by many of the men throughout the state, but it should be.

We will say we are living in Wood county and that a case comes from Clark county or Taylor county or Marathon county; the county in which the work is done can charge it back to the other county and they must pay the bill. It is difficult to get some of those town chairmen to co-operate, as you realize if you have done any work for them at all.

Dr. E. S. Knox (Green Bay): I listened with a great deal of interest to Mr. Blank's very fine discussion of the Iowa plan for caring for the indigent patients. There are a few things on which I would like some additional information as to how they deal with the situation in the larger county. In our county, and I think it is true of much of the surrounding territory, the county has a physician to whom they pay fifty dollars a month. This county physician takes care of all the patients in the county and also takes care of the county poor farm patients and the county asylum indigent. Then there is our city physician chosen by the city council, who gets a definite salary, we will say $300 a month. Those men are supposed to take care of all the indigent patients in the city and county. I think the Iowa plan would be a fine one to use to get some money to carry on our county society, but I do not know just how to go about the idea of supplanting the county physician and the city physician with the County Medical Society. You would involve yourself in quite a little politics, and I wonder how you would take care of that matter.

Dr. R. L. MacCornack (Whitehall): This is a very interesting discussion. I came to the conclusion Mr. Blank was pretty enthusiastic when he gave that talk on the Iowa plan. But the thought came to me that we represent three counties, Trempealeau, Jackson, and Buffalo. Twenty per cent of the secretaries represent more than one county. I am wondering if the time is not coming, if such a plan as you suggest is worked out, when each county will have to have its own society. We, who live in sparsely settled communities, combine at the present time because there is only a doctor here and there interested in this type of thing. The other members of the profession, in these sparsely settled communities do not care at all about working with their colleagues.

With this plan put into operation, in some of the counties of the state of Wisconsin, it may become necessary to rearrange the medical society. I wish you would say a few words about that one point.

We are discussing the matter of uniting for a common purpose, and I think it is time that this movement be discussed and put into operation in many places. The greatest trouble now is to get many of the members of the profession in our county interested in this kind of work, and I see in this an opportunity to get the men to pull together. In discussing the matter with our President, Dr. Harper, a moment ago, he suggested it was going to be necessary for us to pull together.

FLOATING POPULATION

Dr. I. E. Schiek (Rhinelander): I have listened with a great deal of pleasure to Mr. Blank's remarks. The thought occurred to me of the problem we have in the northern part of the state. We have a large floating population, especially among the lumber jacks, who have no real legal residence. They work in a camp for a certain length of time, quit and go to some other camp. A great many of those men who are familiar with no other industry than that of logging are very improvident, with the result that in most cases shortly after they get their spring pay for the winter's work they are really indigent patients.

Among that class of people, and there are many of them up there, we have a problem whereby the supervisors in the various townships, the poor committees, deny any responsibility or any liability for that group of men. We have some pathetic instances of railroading those men from one county to another and having the poor commissioner discover them, put them in an automobile and send them to the next county. It is also a common occurrence for the chiefs of police in our cities to pick up these men, put them on a train and get them to the next town if possible.

In connection with Mr. Blank's remarks, as to how this work was apportioned with such an arrangement, and whether a great deal of responsibility did not fall upon a certain few, and primarily whether the patient would be given the choice of whom to select, and whether the supervisors in the various townships and communities, such as we have, would not throw up their hands and say about those indigent people, when the problem comes up, "Where are you going to draw the line?"—I think our supervisors are more or less human and like to get off their hands a situation such as I mentioned.

I think the problem in our particular community is a little different from that in most other county organizations in the state. I would like to go back with some concrete idea of helping the group in our society with some definite plan. So far I have not been able to satisfy myself on this score. I think it would be rather a political football for us to place ourselves open to contract with the powers in charge of that kind of work in our community.

Dr. Spencer D. Beebe (Sparta): I do not believe I can elucidate on this matter. I would like to refer, however, to a problem that exists in our society now. Mr. Wylie brought it up and I suppose Mr. Blank is familiar with it. The question is: When is a man indigent; when is he a proper case? Our supervisors have ruled that a man is not a subject for county care unless he is absolutely indigent and has no property in any shape or manner. Suppose we adopt this other plan, immediately the supervisors will change their opinion about who is an indigent person and three-fourths of the population will be indigent.

To me, the outstanding thing about Mr. Blank's plan is that it almost inevitably brings the men of the county society together. Whether this one plan fits every county remains to be seen, but the fact of the matter is every county will find a great deal of stimulation in getting together on any proposition, whether it is this one or some other.

Dr. Otho Fiedler (Sheboygan): One thing that appears is a new element of medical ethics in this whole problem. One of the things the medical profession has frowned upon is any contract practice in which you fix a definite fee for an indefinite amount of work. Under this plan we say that for a definite, fixed sum we will do what work is presented and thus have introduced a new element, so far as the ethics of the medical profession is concerned. Once you have said that this is a group of patients for whom you will do certain things under certain conditions and for a certain fee, is there not some question that you would not have another group who will say, "The medical costs, hospitalization, surgical and specialized service are quite outside of the possibility on our part to pay," and whether they will not clamor for another contract under which for a certain sum, or at a certain rate, they will ask for a like medical service.

I am not saying that may not be a good thing. I am not sure. But I want to say this movement on the part of these county societies in the state of Iowa is a movement in the direction of socialization of medical practice, and I wonder whether once introduced, if that wedge is going to go a little deeper into one class of society after another until the medical practice generally will be a socialization service instead of an individual service conducted between the patient and his physician. The medical profession then will be organized to render a service to society instead of the individual rendering a service to the individual.

Dr. G. J. Hathaway (Superior): We seem to have a great many charity organizations throughout our community. We have a full time county health officer who is a physician, who takes care of all the indigent. But, in addition to that, in the city we have two school physicians, a dentist and two school nurses. In the course of their examination, they have found a good many children with enlarged tonsils and various defects. They became enthusiastic, a few years ago, and expressed the desire to have such defects remedied. They felt that the individual members of the County Medical Society should do all this work. They agreed that they would pay the hospital bills but thought that the physician should do his part gratis. To this we protested.

It took such a pass that eventually they were going to hire a man to do this work for them. We countered with a proposal that if they had money to hire a man to take care of this work we would be glad to do it and put in a bill for it. So this work has been referred to the different members of the society who are practicing that branch of

medicine. The bills have been rendered to the Parent-Teachers' Association, and were paid as far as their funds permitted. I think they paid quite a fair proportion of it and are still obligated to pay the balance. Recently there has not been any demand for more work. They have been quite satisfied, I think, with the service, but have not demanded much more.

I think the County Medical Society stopped a lot of propaganda, not interfering with the county physicians, who seemed to be taking charge of that work adequately. But it was handled by the society as a unit where it seemed the society would be split up by one of the members taking the work on the basis which would have made the individual fees very small. We kept our unity by such arrangement.

Dr. Beebe: May I ask the last speaker, in regard to the county physician, does he do all over the county?

Dr. Hathaway: He is a full time man and draws a salary of $3500 a year and takes care of the county.

MODIFICATION ESSENTIAL

Mr. Blank: The fact which I did not make perfectly clear in my original remarks was that it is, of course, always necessary to modify this general plan to meet local conditions. We have in Iowa fifteen county societies with contracts, and fifteen different contracts. They have a number of common denominators, but no two of them are alike. It was to aid those societies in planning new contracts, to select the various details which appealed to them, that we have prepared the little chart you have in your possession. We have also tried to maintain a file of complete copies of all contracts. I have just added to our armamentarium this Polk county contract which Mr. Larson has prepared, and he is to be congratulated on the fine work he has done. I have contracts from two or three other states, and am trying to maintain as complete a file as possible. There is a distinction between the urban and rural. We are not beyond communities of 50,000 as yet, and, of course, that still does not interest men like Mr. Wiprud, in the larger centers. We are going to try to work out the plan in Des Moines in the next few years.

In the rural community, the general procedure is to allow the patient to go to whichever physician he chooses. That generally works out well. We have one rural county society where the secretary, who is semi-retired, receives fifty dollars a month because he renders the service of distributing the work, and tries to do it so that over the course of a few years each man contributes the same amount of work even though he may sometimes send one physician further than another would have to go on a given case in order to equalize the services rendered.

There is no great objection regarding the men taking the cases that come. Those getting the most of the private pay practice may get the most charity work, but they seem to be glad to do it, apparently under the theory on which income taxes are levied. He who receives most can give most.

In the city, a different procedure has been used. We have two cities which have adopted the plan. One is Davenport and the other is Council Bluffs. In both of those places, a physician has been employed, a younger member of the society just getting started, to take care of all house calls. The young man in Council Bluffs has been averaging about $2.20 per call. The man in Davenport was getting about $3.00, so they reduced his salary the second year and he will get about $2.25 per call. The rest of the work done in Council Bluffs is through the two hospitals. Each is on tour of duty for a three months' period, during which time the staff is entirely responsible for rendering all service to indigents who come there. They maintain a clinic dispensary and the men are divided into their specialties. There are two hours of each day for general cases and one hour each day of the week for the different specialties. The cases are hospitalized in that hospital during the three months. Nobody in Council Bluffs receives any pay for the services rendered expect the young man who gets a salary of $100 a month.

In Waterloo, a city of about 35,000, the physicians are divided by their specialties, each on duty for two months of the year. The overseer of the poor has that list for each sixty-day period, with the men classified, and calls them in rotation according to the need; so the work there is distributed fairly evenly. Only two of our counties divide the money. They divide it, however, only after all local, state, and A. M. A. dues are paid, and after the general overhead has been paid. Each man keeps track of all services rendered under the contract and sends the bill to the secretary. A committee has to meet quarterly and go over those bills, sometimes cutting a bill or calling a man in and going over it with him. They divide the total of the bills by the amount of money they have left and have been paying seventy to eighty per cent of the regular fee. That is advisable only in a county where the services are necessarily of an uneven nature, where you cannot have an even distribution of services among the members, or where for personal reasons some of the members will not agree to keep the money in the treasury and use it for the advancement of the profession. We have urged upon the Iowa county societies not to divide the money but to use it for the good of organized medicine.

In Iowa, as a matter of general policy, we try to avoid the unification of counties in one society. We have ninety-seven societies. It is necessary to operate as county units in this connection, because your dealings are with governmental units of the county system. Your three or four counties could still maintain their scientific programs and other relationships; but there would need to be county organization for the purpose of the contract.

When I heard the gentleman from northern Wisconsin speak about the lumber jacks, I was wondering whether they came under the Workmen's Compensation law of Wisconsin.

Dr. Schiek: They do when they are working.

Mr. Blank: That makes an acute problem. I wish to call to your attention a specific and very prudent provision in the Polk County contract, which specifically states that nothing in the contract shall prevent a physician, in attending a person whom he thinks can pay, from rendering a bill for those services. That should always be provided. You are not obligating yourselves to take care of any person who can pay. In several of the Iowa contracts, they specifically provided that only those receiving other services from the county would be included in this contract. If the county is paying the grocery bill, buying clothes, or something of that sort, you know they are honest-to-goodness county cases, because the supervisors are laying out cash for them. If you wish, you may accept that test, or accept the simpler one which Polk County has; a man can pay or cannot pay. If you cannot get anything from it, what difference does it make? If you can, the supervisors are not going to object.

If your contract contains such a provision as is in the Polk County Society contract, you would safeguard against such impositions. If you cannot collect from a patient, you are not out anything. It is purely a theoretical consideration.

I noticed in the Polk county contract they have quoted a section of the code which determines indigency. It is true, I believe, in all states that the legal term for indigency is much stricter than that applied. If the Iowa code were applied, I presume only about one-fourth of those now receiving county aid would be included in the provisions of the law.

Dr. Fiedler's point, of course, is an extremely important one. I have not felt that this project was either hastening or retarding the tendency, if any, toward socialization of medicine. But I do feel that it is a positive preventive of state medicine, keeping in mind the definition which we gave this morning, that state medicine is that type of medical practice in which some outside agency steps in and controls the situation and comes between physician and patient. Socialization of medicine may be group practice. I do not know what it might be, but if it keeps the power, the control, in the hands of the physicians, and as long as they are united we cannot go very far wrong. If the thing is coming, if circumstances force it, the thing to do is to make the best of the situation; and the best of the situation is to have a united profession, with every procedure determined, controlled and in the hands of the members of the medical profession. This plan accomplishes that, whether or not you choose to do as they did in Douglas county, to deal with the lay agencies just as we are dealing with the state agencies. Eventually it may come to the whole borderline group between county paupers and those able to pay a regular fee. But it will not be state medicine as long as the medical profession operates on a united guild basis.

It is bad business, of course, to operate under a blanket contract unless you carefully keep it in line with what would be paid for the services on an individual fee basis. So most of the counties which have contracts, either every year or occasionally, instruct their members to keep a careful record and submit bills to the county secretary, and then go to the supervisors and tell them how much service they are rendering. The first year Davenport operated under this plan they found the services amounted to $17,400. The amount was then raised by the supervisors from $12,600 to $15,000. In Washington County, they got $1,600 the first year and found they delivered $2,000 worth of services and are receiving $1,800 this year.

I will conclude my remarks by saying this is only a general plan, that it must be adapted to the locality, and that you will find as many different kinds of contracts and working arrangements under the plan as there are societies entering into it.

Mr. Wylie: I would just make one suggestion. At first the thought occurred to me that the blanket contract would result in overloading, but if you only make the contract for a year at a time, you may get overloaded the first year, but when the county sees they have to make a raise, they will get back to making a close check, because they know when the next year comes they will have to raise the price if they put on too much work.

Chairman Sexton: We certainly feel greatly indebted to Mr. Wylie and Mr. Blank.

Secretary Crownhart: Before we close the discussion, may I add this,—while the State Society, in legal service, is bound by the budget and is reluctant to aid individuals or county societies unless the question is one that affects the whole state, we have the conviction that these contracts are questions that do so affect the whole state. Upon the success of one may depend the future as far as other counties are concerned. If any county seriously contemplates entering into such contract, we will be happy to word it for you. The terms must be your own. We will only endeavor to aid you with the legal phraseology of the contract to avoid group liability and other danger points which are important and might not enter your mind.

Mr. Larson: I do not wish to take any undue credit for the contract of the Polk County Society. They have followed the Iowa plan in a great many ways, and the contract was prepared through the legal counsel of the State Society.

MEDICAL EXAMINERS MEET

The State Board of Medical Examiners meet in Milwaukee on Tuesday, June 30th, for their semi-annual three-day session to admit candidates by both examination and reciprocity.

Senate Kills Assembly Bill to Provide Free Choice of Physicians Under Workmen's Compensation Act by Vote of 17 to 10

The Beggs bill for free choice of physicians in compensation cases was killed in the senate on Thursday, May 21, 17 to 10, and the upper house then refused reconsideration so the measure cannot again be revived at this session.

The senate first adopted a substitute to the bill which would have opened the way for injury victims to choose treatment by a chiropractor besides having the choice of any doctor he may desire instead of being limited to one of the physicians listed on an employers panel. The substitute was adopted without a roll call.

"As I view the bill, it is to place these cases in the hands of a few physicians who may not be called now", Senator Walter S. Goodland, Racine, said. "You should think a little before placing any more burdens on industry and I know that industry is suffering today as much as anybody. I think it is an iniquitous act."

"I think that this is a very fair bill", Senator Walter Polakowski, Milwaukee, said. "I know of a case where the industrial commission made an award for the loss of an eye on the recommendations of a company doctor. On the recommendations of his own doctor the award was later doubled."

"There are two factors in this", Senator James Barker, Antigo, declared. "The injured man can choose his doctor and the employer must pay the bill. There is no question but that employers have the best medical experts they can get. They are interested in getting the injured man back on the job as fast as possible. It is a matter of business with them. Very few agree on doctors and doctors are not all alike. Some are still using the herbs of 100 years ago. Maybe that is all right but there is a difference of opinion. We all know that many of the old-time physicians have been lost entirely because of the progress made in medicine and surgery and they have not been able to keep up. But that wouldn't make any difference to the injured man. The longer he is in bed the more compensation he would get. This bill is unfair to employers."

"I am heartily in favor of this bill", Senator Leonard Fons, Milwaukee, said. "I know of a case where the family doctor disagreed with the panel physician. The panel doctor took the family doctor out to dinner and entertained him and the two agreed to another examination. The family doctor then came to the conclusion that the panel doctor was right. This bill would not add a penny to the cost for any employer."

Senator L. J. Fellenz, Fond du Lac, urged waiting before acting on the bill. He said that he wanted to wait for the recommendations of the industrial commission and a bill the commission would suggest.

On the vote of 17 to 10 to kill the bill, Senator George Blanchard, Edgerton, moved to reconsider the bill so that it could not again be brought up at a later date. Senator Polakowski then declared that he hoped the bill would be reconsidered so that an amendment might be offered. But reconsideration was refused, 13 to 14.

The vote killing the bill was:—

For the bill—Cashman, Duncan. Fons, Keppel, Loomis, Olson, Roberts, Severson, Smith, and Zantow—10.

Against the bill—Anderson, Barker, Blanchard, Clifford, Daggett, Edwards, Fellenz, Gettelman, Goodland, Hall, Mehigan, Miller, Morris, Mueller, Roethe, Shearer and White—17.

An open hearing on the bill was given by the Senate Committee on Agriculture and Labor previous to the Senate vote. The report on this hearing indicating the opposition to the measure, follows:

FOR THE BILL

Assemblyman C. A. Beggs, Rice Lake: There isn't much to bill 71-A except that it provides free choice of physicians under the workmen's compensation act. It provides that injured workmen may choose their own physicians. All other parts to the bill such as fee regulation, services, and so on are all under the Industrial Commission. This practically covers all the bill contains. Over in the Assembly there was an amendment put on by re-

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PRESS SERVICE OF STATE MEDICAL SOCIETY

No serum does so much for public health as printer's ink

OVERWEIGHT

Madison, Wis., April 29.—Springtime is the best time of the year to exercise and reduce weight. More lives can be saved in the next few months by getting out in the sunshine and doing a little work than can be reclaimed next winter by physicians' prescriptions.

"At the age of 45, forty pounds overweight shows an excess mortality of 50 per cent," declares the Educational Committee of the State Medical Society in a bulletin issued today. "In other words, three die when but two should."

This startling statement is the introduction to the Health Committee's bulletin of the State Medical Society issued today. The bulletin declares that tremendous strides have been made in recent years in saving the lives of children, who have heretofore died of communicable diseases, and points out that the lengthening term of life of individuals is due to the prevention of children's diseases, rather than to conquering the diseases of adults. It predicts that the time will come when all persons will be annually examined and an inventory taken of their health conditions to reduce unnecessary early adult deaths.

"In 4100 consecutive persons, taken just as they appeared, only 74 had normal teeth, and 58 per cent or 2,700 had actual root abscesses; 648 had well marked heart damage and 492 had combined heart and kidney damage," continues the bulletin. "And of these, more than ten per cent had no idea of anything wrong with them.

"There is but one way to secure better results. We must do as has been done with the babies and the tubercular. Prevent or begin cure while the disease is trivial and incipient.

"In these groups, there were to be expected under standard mortality tables, which are uncanny in their exactness, three hundred and three deaths. In the examined and advised group, actually there were two hundred and seventeen,—a saving of seventy-two lives, varying between twenty and forty-five in five years.

"We do not hope to banish illness and death but we fairly may expect with competent periodic physical examinations, to lessen illness in those between twenty and sixty, to prolong the average life of the adult and to minimize the economic loss among those who carry on the work of the world."

SUNSHINE

Madison, Wis., April 22.—If people will open their windows and let in the fresh air, throw back the curtains and let in the sunlight, much of the gloom of winter will vanish and the lurking threat of disease will be driven out.

The Educational Committee of the State Medical Society of Wisconsin in a bulletin issued today declares that sunshine is a magic worker, sometimes more potent than medicine. People who have had their houses shut up all winter should use the early days of spring for a rejuvenation and for letting in the sunshine.

"Sunlight will kill more disease germs than any antiseptic," declares the State Medical Society's Bulletin issued today. "Sunshine can be literally lapped up by the skin and ultimately reach even the marrow of our bones.

"Sunshine is almost as much of a magic worker in animals as in plants, although the wonders performed are of a different character. Plants are the great conservers of energy; animals are the great dissipaters and users of energy. But if man lives in the sunshine, he too, becomes to a degree a conserver of energy. It is estimated that the outdoor dweller receives a thousand times more sunlight than the indoor dweller gets. But more important still, he who lives outdoors with the God of the open-air receives millions of times more ultra-violet radiation than he who lives behind the transparent sands of the window pane, for this robs the sunshine of its ultra-violet content in large measure.

"Scientists know that one of the most important things in the world is sunlight. As yet they are ignorant about many of its attributes and effects. They do not know for sure why light stimulates and heat depresses; why some people tan and others do not; why those who pigment most easily get the greatest benefit out of sunlight treatments; why foods tha contain no vitamins, such as vitamin D, which is so essential to the growth of bone, develop considerable quantities of these essential substances under exposure to light; why tuberculosis affects cattle in proportion to the time they live under cover and away from sunshine; why the calcium and phosphorus content in milk from pasture-fed cows is greater than from cows living in the shade and fed on dry fodder; why irradiating the cow or even the milk gives a food that is effective in preventing and curing rickets and other metabolic disturbances in growing children.

"Sunlight cures rickets and is a big factor in the stamping out of consumption. A few minutes' exposure to outdoor sunlight daily has been known to increase almost two-fold the quantity of phosphorus in a baby's blood in a few weeks' time. The rays of the sun materially increase the iron content of the blood and help to keep us from becoming anemic."

MENTAL HEALTH

Madison, Wis., May 13.—Suspicions and irritableness are an indication of an unhealthy condition. More and more, science is discovering that mental symptoms color the world about people.

The Educational Committee of the State Medical Society in a bulletin issued today declares that healthy people may dream dreams but never escape from facts; they face truth but never become morbidly introspective or deadly unimaginative. The bulletin adds that people who find themselves easily irritated, suffering from shyness and fear, should attempt to build up their mental health.

"Most persons are beginning to realize that to meet each day's program with interest is as important as to meet it with physical vitality; that to be cheerful, resourceful, tolerant and self-controlled is to give evidence of mental health and that such traits are not chance gifts of personality decreed at birth by the whim of fate but are to be achieved through healthful living," declares the bulletin. "Following the pattern of the current idea of physical health, mental health is understood to mean vitality both for daily demands and for emergencies. Any emergency either of good or evil event tests the stamina of mental health, for it is as difficult to meet brilliant success without losing one's head as it is to meet failure or misfortune. Sound health habits will do much to build the stamina necessary to meet both physical and mental emergencies.

"The sick personality is likely to present certain definite symptoms. Among these are shyness, hyper-

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THE JOURNAL BOOK SHELF

Infant Feeding in General Practice. By J. V. C. Braithwaite, M. D., M. R. C. P. (Lond.), physician and physician in charge of Children Out-Patients, Leicester Royal Infirmary and Children's Hospital; late assistant Queen's Hospital for Children, London. Price $1.75 net. William Wood & Co., 156 Fifth Ave., New York, N. Y.

A Manual of Diseases of the Nose, Throat and Ear. By E. B. Gleason, M. D., professor of otology, Graduate School of the University of Pennsylvania. Sixth edition, thoroughly revised. 12 mo. of 617 pages with 262 illustrations. Cloth, $4.50 net. W. B. Saunders Company, Philadelphia, and London.

Nursing Technic. By Mary C. Wheeler, R. N., former superintendent of Illinois Training School for Nurses; and Amalia Metzker, R. N., instructor, St. Luke's Hospital School of Nursing, Racine. Third edition completely revised and reset. J. B. Lippincott Co., Philadelphia.

Clinical Allergy, Particularly Asthma and Hay Fever. By Francis M. Rackemann, M. D., physician to the Massachusetts General Hospital; Instructor in medicine, Harvard Medical School. Price $10.50. The Macmillan Co., 60 Fifth Ave., New York City.

Ante-Natal Care. By W. F. T. Haultain, O. B. E., M. C., M. B., senior assistant obstetric physician and late special assistant to ante-natal departments, Edinburgh Royal Maternity and Simpson Memorial Hospital. And E. Chalmers Fahmy, M. B. (Edin.), assistant obstetric physician and special assistant to ante-natal department, Edinburgh Royal Maternity and Simpson Memorial Hospital. Second edition. Price $2.25 net. William Wood & Co., 156 Fifth Ave., New York, N. Y.

Modern Methods of Treatment. By Logan Clendening, M. D., professor of clinical medicine, lecturer on therapeutics, medical department of the University of Kansas. Fourth Editlon. Price $10.00. C. V. Mosby Company, St. Louis, Mo.

Chinin In Der Allgemeinpraxis unter Berucksichtigung Pharmakologischer Befunde. By Dr. Med. Fritz Johannessohn. On demand, copies will be sent to medical men free of charge. Address, Bureau for Increasing The Use of Quinine, P. O. Box 215, Amsterdam-W, Holland.

Modern Surgery. By J. Chalmers DaCosta, M. D., LL.D., F. A. C. S., Samuel D. Gross, professor of surgery, Jefferson Medical College, surgeon to Jefferson Medical College Hospital, consulting surgeon to the Philadelphia General Hospital, St. Joseph's Hospital and Misericordia Hospital, Philadelphia. Assisted by Benjamin Lipshutz, M. D., F. A. C. S. Surgeon to the Mt. Sinai Hospital; associate in neuro-anatomy, Jefferson Medical College. Tenth Edition, revised and reset. 1404 pages with 1050 illustrations, some in colors. Philadelphia and London. W. B. Saunders Company, 1931. Cloth, $10.00.

Insomnia. By Joseph Collines, M. D. Price $1.50. D. Appleton and Company, New York.

BOOKS RECEIVED FOR REVIEW

Clinical Diagnosis by Laboratory Methods. By James Campbell Todd, Ph. B., M. D., late professor of clinical pathology, University of Colorado, School of Medicine; and Arthur Hawley Sanford, A. M., M. D., professor of clinical pathology, University of Minnesota (Mayo Foundation); head of section on clinical laboratories, Mayo Clinic. 7th edition, thoroughly revised. 765 pages with 347 illustrations, 29 in colors. Price cloth, $6.00 net. W. B. Saunders Co., Philadelphia and London, 1931.

Chemistry for Nurses. Including Certain Essential Principles from Inorganic, Organic and Biochemistry. A combined text and laboratory manual. By Harry C. Biddle, A. M., instructor in chemistry, School of Nursing, Western Reserve University; lecturer in chemistry at St. Lukes Hospital, Cleveland. With 74 illustrations. Price $2.75 net. F. A. Davis Company, Philadelphia.

Nutrition and Diet in Health and Disease. By James S. McLester, M. D., professor of medicine at the University of Alabama, Birmingham. Second edition, revised and reset. Octavo of 891 pages. Price cloth $8.50 net. W. B. Saunders Company, Philadelphia and London.

The International Medical Annual. A Year Book of Treatment and Practitioner's Index. Editors: Carey F. Coombs, M. D., F. R. C. P. and A. Rendle Short, M. D., B. S., 49th year. Price $6.00 net. William Wood & Co., New York, N. Y.

Heart Disease. By Paul Dudley White, M. D., instructor in Medicine, Harvard Medical School; physician, Massachusetts General Hospital, Boston. Price $12.00. The Macmillan Co., 60 Fifth Avenue, New York. 1931.

Diagnostic Methods and Interpretations in Internal Medicine. By Samuel A. Loewenberg, M. D., F. A. C. P., associate professor of medicine, Jefferson Medical College; assistant physician to the Jefferson Hospital; visiting physician to The Philadelphia General Hospital, The Northern Liberties Hospital and the Eagleville Sanatorium for Consumptives. With 547 illustrations, some in colors. Second revised edition. Price $10.00 net. F. D. Davis Company, Philadelphia, 1931.

Hemorrhoids, The Injection Treatment and Pruritus Ani. By Lawrence Goldbacher, M. D., Philadelphia. Illustrated with 31 half-tone and line en-

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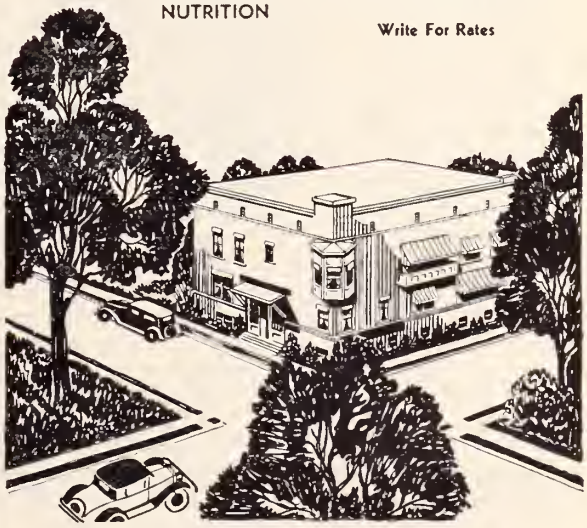

gravings, some in colors. Second revised edition. Price $3.50 net. F. A. Davis Company,. Philadelphia, 1931.

Practical Dietetics for Adults and Children in Health and Disease. By Sanford Blum, A. B., M. S., M. D. Head of department of pediatrics, and director of the research laboratory, San Francisco Polyclinic and Post-Graduate School. Fourth edition revised and enlarged. Price $4.00 net. F. A. Davis Company, Philadelphia, 1931.

The Physician of the Dance of Death. A historical study of the evolution of the dance of death mythus in art. By Aldred Scott Warthin, Ph. D., M. D., LL. D., professor of pathology and director of the Pathological Laboratories in the University of Michigan, Ann Arbor. 92 illustrations. Price $7.50. Paul B. Hoeber, Inc., New York, N. Y.

The Treatment of Injury by the General Practitioner. By Clay Ray Murray, M. D., F. A. C. S., assistant professor of surgery, College of Physicians and Surgeons, Columbia University; associate visiting surgeon Presbyterian Hospital in the City of New York. With 196 drawings by the author. In two volumes. Price of two volumes $5.00. Harper & Brothers Publishers, New York and London. 1931.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Secretary, Mr. J. G. Crownhart, 119 E. Washington Ave., Madison, Wisconsin. These new books will be loaned for an inspection period only.

Selections from the Papers and Speeches of John Chalmers DaCosta, M. D., LL.D., Samuel D. Gross, Professor of Surgery, Jefferson Medical College, Philadelphia. 440 pages. Cloth, $6.50. W. B. Saunders Co., Philadelphia and London.

This is a book that every physician should have in his library. Dr. DaCosta's various papers and sketches are most interesting, among them are those on Dickens' Doctors; one on Barry Larry, who was Napoleon's great surgeon; reminiscences of the Old Blockley Hospital and the Old Jefferson Hospital. Character sketches of Professor Samuel W. Gross, Crawford W. Long, the discoverer of ether anaesthesia, of W. W. Keen, and a description of Medical Paris during the reign of Louis Philippe.

But best of all, his orations and addresses before students and medical societies emphasize the high ideals of the practice of medicine, which are so apt to be lost sight of in this practical and commercial age. This book contributes largely to the best of medical ethics. R. C. B.

Discovering Ourselves: A View Of The Human Mind And How It Works. By Edward A. Strecker and Kenneth E. Appel. New York: The MacMillan Co. 1931. 306 pages. Price $3.00.

The authors state at the outset that this book was not intended for psychiatrists and psychologists. This the reader happily perceives, for few technical terms are found and when they are used, they are very clearly defined. Those dealing with mental disorders can find much of practical value in perusing the pages of this book. The physician should find much of interest, particularly in chapters 2 and 3, with reference to the relationship of mind and body and it should be helpful to him in the understanding and treatment of his so-called nervous patients. The student and even the layman will find a great deal here that should assist them in making or maintaining adequate mental adjustments.

After discussing nervousness, certain elementary psychological concepts, the conscious, subconscious and unconscious, the authors describe briefly but clearly, the various mental mechanisms,—complexes, conflicts, regression, extroversion, introversion, phantasy, rationalization, segregation, repression, dissociation, conversion, substitution, symbolism, projection, identification and inferiority. Not only are these mechanisms elaborated upon in their role of mental hazards, but their avoidance is likewise discussed. Many statements are found that are nicely put, such as, "We have the contradictory situation, therefore, of nervousness in the presence of a nerve system which is apparently normal, and actual disease of the nerves without nervousness." Or again, "Often we fail to see ourselves as others see us, and then, usually we are acting in the service of some complex."

The theme of the book is very well carried out, there are very few weak spots and altogether it is written in a most interesting style. During the course of the manuscript, there are found numerous diagrams which impress one as being quite clever and graphic. The volume is a real contribution to mental hygiene and one can say for it that it is both scientific and constructive. R. E. B.

Crippled Children. By Earl D. McBride, B. S., M. D., F. A. C. S. Instructor in orthopedic surgery, University of Oklahoma, School of Medicine; attending orthopedic surgeon to St. Anthony Hospital; associate orthopedic surgeon to Oklahoma City General and Wesley Hospitals. Price $3.50. C. V. Mosby Company, 3523 Pine Blvd., St. Louis, Mo.

There is here presented a compact resume of the salient features of orthopedic surgery in its application to the diseases, malformations, and injuries of the bones, muscles and nerves in children.

It is not intended as a text or reference book for the Practitioner; rather it is a primer of orthopedic surgery for the laity. For one interested in the crippled child who wishes a working and more than just a superficial knowledge of the problems involved this volume is intended. The illustrations are numerous and enlightening. The text simple, uninvolved and well within the scope of understanding of the unscientific reader.

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It is an outline description of the more usual conditions cared for by the orthopedic surgeon and suggests a means for their early recognition. It should have many friends amongst social workers and parents. L. D. S.

Physical Therapeutic Technic. By Frank Butler Granger, M.D., late physician-in-chief, Department of Physical Therapeutics, Boston City Hospital; assistant professor of Physical Therapy, Tufts Medical School. With a foreword by William D. McFee, M. D., Boston, Mass. Octavo volume of 417 pages with 135 illustrations. Price $6.50 net. W. B. Saunders Company, Philadelphia and London, 1929.

This book is written for the private practitioner who may need guidance in handling the few pieces of physical therapy apparatus which it is possible to install in a general practitioner's office and the author frankly says that best results in this work are only obtainable by several kinds of therapy in really getting results.

This book will make the use of this form of treatment a little safer in the hands of a man who is not best qualified to give these treatments and on the theory that half a cure is better than none, it is entitled to a half-way endorsement. Complete physical therapy, however, in the hands of experts, in these days of the automobile, is available in 30 to 60 minutes ride. E. D. S.

Obstetrics. A textbook for the use of the students and practitioners. By J. Whitridge Williams, professor of obstetrics, Johns Hopkins Hospital, Baltimore. Sixth enlarged and revised edition. With 17 plates and 730 illustrations in the text. D. Appleton & Company, New York and London.

In the present edition the author has attempted to give a complete description of the advances made in the anatomy, physiology, development and pathology of the organs concerned. More space has been used in the discussion of anesthesia in obstetrics, the advantages and technique of caesarean sections of the low cervical type and also the entire problem and treatment of toxemias of pregnancy. As in previous editions conservative treatment of obstetrics and its complications is always very apparent as it should be, for this text is used primarily for instruction of students and guidance of practitioners. There are 40 additional illustrations and many of the old have been replaced by new ones. A. H. L.

MEDICAL LIBRARY SERVICE

NOTE ON THE HISTORY OF TUBERCULOSIS

In Flick's *Development of Our Knowledge of Tuberculosis* we find this very apt statement: "Tuberculosis has meant a different thing to the physician in different epochs of history. In ancient times when the doctor recognized it by its ravages only, he formulated his ideas about it partly by the symptoms which it set up and partly by the damage which it did to the human organism. He sought an explanation for it in the weather, in habits of life, in qualities of food and even in the varying states of the human mind. * * * Some of the names under which the disease was covered up are: scrofula, white swelling, empyema, abscess of the lungs, ulceration of the lungs, hectic fever, hemorrhage of the lungs, lupus, consumption of the stomach, consumption of the liver, hip-joint disease, inflammation of the bowels, chronic diarrhoea, meningitis, abscess of the chest, pleural abscess, psoas abscess, asthma, caries, chlorosis, congestion of the lungs, debility, dropsy of the lungs and emphysema."

References to these diseases with tuberculosis as the apparent meaning have been found in the records of India and China in pre-Christian centuries. The Greeks, especially as shown in the Hippocratic writings, were quite well aware of a number of different forms of the disease, and even used methods of treatment not so far at variance with those of modern times. As so much of the Greek civilization was taken over by the Romans it is not surprising to find a somewhat similar knowledge among them, but, as in many other adoptions from the Greeks, this knowledge did not equal that of the Greeks as may be seen by the mention made by the Plinys, Celsus and Aretaeus. Galen, however, was a better borrower. It is interesting to learn that, whereas the unity of the various forms of tuberculosis was not realized by the Greeks and Romans, the presence of tubercles called by the Greek name "phymata"—was recognized. The Romans emphasized the use of milk in the diet of afflicted people.

From the time of Galen in the second century until the seventeenth there seems to have been little advance in the knowledge of tuberculosis. Sylvius is credited by de Lint as first using the term "tubercle" in designating the consumptive lung lesions. To him also, as professor of Clinical and Anatomical Medicine at the University of Leyden, is probably due the credit of first associating the lymphatic system with tuberculosis, but he believed that these lesions arose from pre-existing invisible glands. William Stark and Matthew Baillie, English pathologists, made a probable correction of this error about a century later, while in France in 1733 Descauet had maintained that the lesions were entirely new productions and not enlargements of pre-existing glands. During the seventeenth century, Thomas Willes, a professor at Oxford, had proved by autopsies that ulceration might be absent from the lungs when death was caused by phthisis, but that "tubercles or stones or sandy matter" might be present.

To Laennec we owe the first thorough correlation of clinical and post mortem findings that established the unity of tuberculosis. The importance of the stethoscope to the clinician might be compared to the influence of the microscope in the laboratory. Although Buhl had suggested the infectious nature of

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tuberculosis, Virchow and the majority of his contemporaries believed it to be constitutional. It remained, however, for Villemin and Koch to demonstrate its specific infectiousness. The two errors made by Koch, namely: that bovine tuberculosis is not transmissible to humans, and that an extract of tubercle bacilli may serve as a specific therapeutic agent, have since been corrected. Other advances, too numerous to mention here, have, of course, been made.

The following books selected by Miss Holford of the Bacteriology department for display in the exhibit on this subject may interest some who prefer more details in this study: Baillie—*Morbid Anatomy*; Flick—*Development of Our Knowledge of Tuberculosis;* Garrison—*History of Medicine*; Hale-White—*Selected Passages from Laennec*; Koch—*Gesammelte Werke* vols. I & II; Laennec—*Diseases of the Chest*; de Lint—*Atlas of the History of Medicine*; *Anatomy*; Sydenham Society—*Extant Works of Aretaeus, and Works of Hippocrates*; Trudeau—*Autobiography;* and Webb—*Rene Theophilus Laennec.* L. M.

PRESS SERVICE

(Continued from page 493)

sensitiveness, suspiciousness, fears of many things or intense fear of a few things, obsessions of all sorts, disgust with many things or excessive disgust with fewer things, boredom, melancholy, emotional explosions of all kinds, failure to get on with people, failure to get on with one's work, tendencies to lie, to steal and to commit violence, laziness, untidiness, quick enthusiasms which fail before work is accomplished, violent dislikes, excessive appetite for food, sexual indulgence, excitement, unreasonable enthusiasm for or aversion to the opposite sex or one's own sex, explosive aversion to the institution of marriage or other standard authorities, too much attention to morbid and sensational movies, magazines or stories, undue humility or self depreciation, blindness to one's own limitations, refusal to take responsibility and inability to make decisions. All these and many other similar traits are listed among the symptoms that indicate an unhealthy personality. They are not, of course, necessarily fatal any more than constipation, frequent colds, occasional headaches, sleeplessness or other symptoms of imperfect physical health. Achievement of perfect health, however, demands a freedom from any such symptoms.

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THE MOUTH

Madison, Wis., May 20.—At least eighty per cent of bad breath have their origin in the mouth. Some is caused from purely dental conditions, others from trench mouth. Breath should not have any noticeable odor if it is normal.

"People with decaying teeth have only themselves to blame," declares a bulletin issued by the State Medical Society today. "Failure to eat foods that will develop the tissues is among the chief causes for bad breath and decayed teeth.

"The cure of a bad breath lies not in taking some sweet smelling tablet or mouth wash but in removing the cause. Regular use of a tooth brush and daily dental hygiene will do much to eliminate wrong mouth conditions, and the maintenance of a healthy body will remove other possible causes.

"Hard breads, toasts, fibrous vegetables, tougher cuts of meat, and fruits with a tough pulp should be added to the diet for cleaning and massaging the teeth and gums, as well as for their food value.

"Closely allied to diet is exercise of the teeth. Many of our meals consist of foods so soft that teeth are not really needed. The teeth and gums are like any other part of the body; unless they are constantly exercised they will lose their firmness and vigor. The development of pyorrhea and other gum diseases soon follows.

"Vigorous chewing of rough foods stimulates blood activity. It stimulates growth and development along with the normal functions of the muscles of the throat, tongue and face. It reduces the production of fat overlying the muscles of the lower part of the face and keeps the skin in tone.

"An important item in the care of the mouth is the prevention of decay; in fact, that is why we take care of our teeth. Prevention of the extension of small decayed spots is extremely important. Infection cannot enter the pulp of a tooth through a tooth wall that is sound. Periodic examination of the mouth is the only sure way of preventing the small cavity from becoming a large one."

KILL FREE CHOICE BILL

(Continued from page 492)

quest which eliminated from the present law a provision for Christian Science in lieu of medical treatment. I was not much interested in that amendment. I understand that Senator Daggett has an amendment, at least I talked it over with him, and he advised that he was going to introduce an amendment restoring that, which is perfectly satisfactory to me. I think that covers all I have to say.

Senator H. B. Daggett, Milwaukee: It is true that amendment 1, A to bill 71, A in the Assembly stikes out the words that had been in the law for many years now,—that employes may have Christian Science treatment if they so desire. I have seen the parties in the Assembly who were instrumental in having amendment 1, A adopted, and they are perfectly willing to have it restored. It has been in the law for many years and has done no harm and a great many people get comfort out of it. I hope that the committee may see fit to have it restored in the bill as it stands now.

Mr. George Ballhorn, Christian Science committee on publication, Milwaukee: The amendment as suggested meets the situation. The statutes require the right to have Christian Scientists, and the amendment eliminated that right. I think it fair and proper that the rights of Christian Scientists should be continued as part of the law.

Henry A. Staab, Wisconsin Chiropractic Association, Milwaukee: We are in thorough accord with the re-establishment of the amendment. We are in favor of an amendment which will also include chiropractors as it does Christian Scientists. It is a fact that in large industrial centers that a tre-

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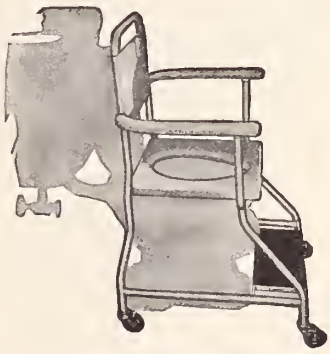

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mendous amount of treatment is done by chiropractors because of back injuries, and we would suggest, if it is possible, to include chiropractors in an amendment as in the Grobschmidt bill 597-A. I might suggest that you offer another amendment here and by so doing you would just avoid hearing another bill. I am sure that the committee would be in accord with it. I approve of Christian Science treatment. I believe that the people should have that right.

OPPOSED TO BILL

Mr. Shomperlen, Pittsburgh Plate Glass Co., Milwaukee: We are opposed to the bill on the grounds that where the employe has the right to select his own physician, he deprives the employer of the present benefit which he would have under the panel system. It is simply going to take the employe back to his own family physician who, without any reflections upon his ability, we feel is not as competent to give surgical and medical treatment to a man who is injured or has some occupational disease. The family physician is not accustomed to handling industrial cases. When an employe goes to his family physician saying he has pains in his stomach, the first thing the physician will say is that he had lead poisoning, while in fact, in the last 8 years we have only had one single case of paint poisoning. We have specialists in eye, ear, nose and throat diseases and we feel that the employe is going to be brought back and given the best attention possible, with as little loss of time, while if the family physician handled the injured employe, he would probably be a little more lenient if the employe did not wish to return to work. Because of friendly relations he would be able to prevail upon the family physician to let him stay out longer than he should. We are interested only in the injured and in getting him fully one hundred per cent recovered and getting him back on the job and not before. We can't see how the employe is going to benefit under this bill. Concerning the amendment in regard to Christian Scientists and chiropractors, we are not opposed to either of them. We are merely opposed to giving the employe the right to select his own physician under the present statute.

Mr. Holzbog, Chain Belt Co., Milwaukee: We wish to go on record as opposed to the bill. We want to say that the employe gets the best possible care from the panel physicians. The employe at the present time has the opportunity to specialists and we believe that the best that can be had in the city of Milwaukee, depending upon what the case is. If the employe selects his family physician he will stay out three or four days or even a week longer than he should, when he should be back to work, because he is friendly with his doctor. We do not believe he would get the best of care because the family physician is not as competent as the specialist.

Mr. Lucas, A. O. Smith Corporation, Milwaukee: We are opposed to this bill. Under the present law the employe received adequate treatment. This type of service is less costly to the employer. The Industrial Commission now has the authority to send an employe to another physician, if the company does not provide competent service. While the present law calls for five, we maintain a panel of 19 physicians. We can see no objection, if thought wise, to submit our panel physicians to the Commission for approval before posting.

Senator Olson: Have you any objection to the amendments? Mr. Lucas: I see no objection to the amendment.

Miss Silvaugh, Oscar Mayer Co., Madison: We carry a complete panel of physicians. The employer wants a man who is injured to receive the most efficient service available for this work. When a man is injured he is immediately sent to a competent physician and is not sent back to work until he is cured 100 per cent. A few weeks ago a man let a box fall upon his foot. I suggested that he have an x-ray taken. He looked over the panel and asked whether he could have his own doctor. He said he would like to have Dr. Schneiders. Knowing that Dr. Schneiders specializes in obstetrics, I explained that he would not be best suited for his case. Injured men must be given the best of care available and it must be given to him at once. I also wish to say that we are not opposed to the amendment.

Mr. Moore, Worden–Allen Co., Milwaukee: When we injure a man we send him to a competent surgeon. In the majority of cases we have specialists. The medical profession as a whole enters into the scheme of settling compensation cases and compensation arguments and practices. We think that physicians who have specialized in one type of work over a period of years and have handled thousands of cases are the most efficient and give the most service to humanity as a whole. Operating expenses in a plant are enough without having others to make it harder to compete with out-of-state concerns. We feel we are reasonably correct when we say that we pay much higher and that we are on a par with adjoining states with regard to wages. Under the present plan we get reports on the condition of the man immediately following the emergency treatment until such time as he is able to come back to work. In that way he will return to work when he should where otherwise he would be permitted to lie around.

Mr. Ralph W. Jackman, representing Carnation Milk Company and Association of Casualty Underwriters, Madison: We are opposed to the bill. It all started because there was one doctor who could not get on the panel in the city of Madison. If a man has to have an operation he is sent to a hospital where he can get the best care possible. We carry our own insurance. We take those men and send them to the best physicians in the city of Milwaukee and we do not pay them on the basis of the Wisconsin compensation act but we pay them full time all the time they are in the hospital. If

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed care Wisconsin Medical Journal.

LOCUM TENENS AVAILABLE: Wisconsin licentiate who has completed internship, externship, and is at present a hospital resident physician is available as locum tenens to take over physician's practice. Address No. 839 in care of the Journal. JJA

FOR SALE—McCaskey desk in very good condition. Originally $350. For further information address No. 832 in care of The Journal. AMJ

FOR SALE—Practice with full equipment and drugs, central Wisconsin college city. Owner wishes to leave to take special work and join clinic. Write No. 834 in care of The Journal. AMJ

WANTED—Eye, ear, nose and throat specialist wants association with physician or surgeon on percentage basis. Able and willing to assist in general practice as well. Address No. 840 in care of the Journal. J

DOCTOR WANTED—Have owned and operated resort for ten years with good increase in business each year. Would like to get in touch with doctor in starting year around health resort. W. A. Kuert, Campbellsport, Wis.

EXCELLENT LOCATION in northeastern part of state, twenty miles by concrete to hospital. Widow desires to dispose of location including office equipment, office and residence. Will sacrifice to make quick sale. Address No. 821 in care of The Journal. JFM

A FINE CHANCE to step into an old established practice. Home and office for sale if wanted. The only doctor in a thriving town of 800 and good farm surroundings. Address No. 835 in care of The Journal. MJJ

FOR SALE—One "Harvard" office chair. Condition good. Cheap for cash. Will G. Merrill, M. D., Wisconsin Rapids, Wisconsin. JJA

SOUTHERN WISCONSIN PRACTICE for sale. Or will rent attractively furnished home and office combined. Good business from start. Address No. 838 in care of The Journal. MJJ.

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FOR SALE—Physician's office and residence in West Bend, Wisconsin, city of 6,000 population. Several churches and schools, public and parochial. A city whose slogan is "the city of diversified industries," and is rated as one of the leading cities in Wisconsin for industry and progress. For further information, address No. 831 in care of the Journal. AMJ

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a man in Richland Center, for instance, has an eye injury under this bill he would go to a local doctor. Ordinarily we would send that man to Madison to have an eye specialist take care of it. Supposing this man goes to Dr. Smith, I don't know whether there is a Dr. Smith in Richland Center, and this doctor attempts to treat him for something he knows nothing about—the man does not get the service. You can't compensate a man for the loss of an eye. He has hard work getting a job in many instances. It is good business to have the man given the best of care. If there is any complaint about a panel physician by the men I would like to see the Industrial Commission given the authority to take those physicians off the panel. The better the man, the quicker the recovery. If this bill is passed it will put the working man into the hands of men who know nothing about the proper care of injuries. You will find that it will be the foreman on the job who will be advising rather than the employer. And foremen have been known to accept compensation or liquor prescriptions.

On page 2 of the bill, the Industrial Commission in its discretion may establish a schedule of fees to be allowed physicians for various standard services in compensation cases and when so established no physician shall be entitled to recover a higher fee for any service than that fixed by the industrial commission. We all know that charges for law practice in the city of Milwaukee and the charges for law practice in a smaller community are not on a par. The expense of living, the expense of office rent make charges higher in cities. You might get a doctor for $3.00 in a village that you could not get for $10.00 in the city of Milwaukee. No doctor can tell what the charges are going to be because every case is different. The commission now has the power and authority to pass upon the reasonableness of the fees and they have been very fair and I can see no reason for the establishment of fee schedules.

CHAPTER 142
WISCONSIN GENERAL HOSPITAL

(As revised by Chapter 80, Laws of 1931. Changes in Italics.)

142.01 *Public Patients.* A person having a legal settlement in any county in this state who is * * * *crippled or ailing and whose condition* can probably be remedied or advantageously treated, if he or the person liable for his support is financially unable to provide proper treatment, may be treated at the Wisconsin General Hospital *or the Wisconsin Orthopedic Hospital For Children* at Madison *or in such other hospital as the county judge shall direct, except that when the person to be treated, or his guardian if he be under guardianship, shall select that such treatment be at the said Wisconsin General Hospital or the said Wisconsin Orthopedic Hospital, the hospital of his selection shall be the place of treatment; provided that the right of such selection shall not exist in counties having a population of five hundred thousand or more.*

142.02 *Application.* When the case of such person shall come to the notice of a sheriff, county supervisor, town clerk, health officer, health nurse, poor commissioner, policeman, physician or surgeon, or any public official, he shall and any teacher, priest or minister may, file with the county judge of the county wherein such afflicted person has a legal settlement an application for * * * *such* treatment at such hospital.

142.03 *Investigation.* (1) The application shall be in such form as the county judge shall direct, and shall contain a full statement of the financial situation of the person and a general statement of his physical condition, and shall be verified. The county judge shall make investigation and the supervisor for the town, village or ward of the legal settlement of the person shall supply to the court, on request all material information within his knowledge.

(2) The judge if satisfied that the required facts exist, shall appoint a physician personally to examine the person. The physician shall make a verified report in writing, within such time as the court shall direct, setting forth the nature and history of the case, and such other information as will be likely to aid in its treatment, and giving his opinion whether the condition of the person can probably be remedied, or should be treated, at a hospital, *and whether the person can receive adequate treatment in the county, at home or in a hospital,* and any information within the knowledge of the physician relative to his financial situation. The physician shall be paid by the county, five dollars, and actual and necessary expenses. *In the case of a crippled person for whom recommendation has been made for hospital treatment, by a recognized orthopedic surgeon, such recommendation may be accepted by the county judge as a reason for commitment of the crippled person to the designated or selected hospital.*

(3) (a) Adequate treatment for a crippled person means that treatment which is given in a hospital which maintains a resident or visiting surgeon who devotes full time to the practice of orthopedic surgery, and the operative treatment given crippled persons in such hospital shall be performed by an orthopedic surgeon.

(b) A crippled person for the purpose of this chapter means one who has some physical defect such as affections of the joints, affections of the bones, disturbances of the neuro-muscular mechanism, congenital deformities, static and other acquired de-

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JELLIED CHICKEN IN CREAM

(Six Servings)

	Gms.	Prot.	Fat	Carb.	Cal.
1 tablespoon Knox Gelatine	7	6	..	..	..
¼ cup cold chicken broth or water	..	..	..	..	..
1¼ cups boiling chicken broth, fat free	..	..	..	..	..
½ teaspoon salt	..	..	..	..	..
Pinch pepper	..	..	..	..	..
1 cup cooked chicken, cubed	125	24	20	..	..
¼ cup cream, whipped	55	1	22	1.5	..
Total		31	44	1.5	526
One serving		5	7	..	88

Soak gelatine in cold liquid for five minutes and dissolve in hot broth. Season with salt and pepper and chill until nearly set. Fold in chicken and whipped cream. Turn into molds and chill until firm. Serve on lettuce or garnished with parsley and strip of pimento.

CARROT and SPINACH MOLD

(Six Servings)

	Gms.	Prot.	Fat	Carb.	Cal.
1½ cups cooked carrots cubed	210	2	1	19.5	..
1 tablespoon butter melted	12.5	..	11	..	..
1 egg well beaten	50	7	5	..	..
1 teaspoon salt	..	..	..	..	..
1½ cups cooked spinach chopped	300	6	1	7	..
2 tablespoons butter melted	25	..	21	.	..
½ teaspoon salt	..	..	..	..	..
Sprigs of parsley	..	..	..	..	..
Total		15	39	26.5	517
One serving		2.5	6.5	4	86

Mash carrots with a fork and mix with beaten egg and one tablespoon of melted butter and salt. Fill small greased molds half full of the carrot mixture. Season the chopped spinach, add melted butter and fill molds to top with spinach, packing them tightly. Place molds in pan of hot water and bake in moderate oven for 20 minutes. Turn out on hot platter and serve garnished with parsley.

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formities, that may be corrected or improved by orthopedic surgery or other special surgical and medical care.

(c) In the case of a crippled person under twenty-one years of age who has been committed to any hospital for treatment, such hospital on discharge of the patient shall make a report to the crippled children division of the state department of public instruction, stating the name, age and address of the child, name of his father or guardian, description of his disability, treatment given, recommendation for after-care, and such other information as said department may require.

142.04 *Findings And Order.* If the court shall be satisfied that the required facts exist and that the person should be treated at the Wisconsin General Hospital, *or at the Wisconsin Orthopedic Hospital For Children, or if the person to be treated, or his guardian if he be under guardianship, selects either of said hospitals as the place of treatment,* he shall so find and enter an order * * * *so directing. If he find the required facts and that the person can receive adequate treatment at home or in a hospital, at the same or less expense to the county, and the person to be treated shall not make the selection aforesaid, he shall enter an order directing such treatment, the place thereof, and the physician or physicians.* If the court is not so satisfied, he may make further investigation. If the court does not find the required facts, he shall enter an order denying the application. Upon granting the application, he shall ascertain from the superintendent of the hospital whether the person can be received as a patient, and if he can the court shall certify his order to the hospital and to the county clerk.

142.05 *Conveyance To Hospital. (1)* If the patient is unable to bear his expense to the * * * *place of treatment,* and the county court shall so order, the county treasurer shall advance to the patient the necessary transportation and expenses out of the county treasury. Likewise, upon the paitent's discharge from the * * * *place of treatment,* the county judge may order transportation and expenses for the patient's return to his residence. If the patient is unable to travel alone *to the place of treatment,* the court may appoint a suitable person to * * * *accompany* him * * * and such person shall receive actual and necessary expenses, and, if not a salaried officer, a per diem of three dollars per day going and returning; and the same shall be paid by the county.

(2) If at the time of commitment the court is satisfied that the patient is unable to bear the expense of returning to his residence or that he will not be able to return alone, the court may at that time authorize the hospital to pay such transportation and expense and may appoint a suitable person to accompany the patient and authorize the hospital to pay the actual and necessary expenses of such person and the per diem provided for in subsection (1). Any hospital making such payments shall be reimbursed by the county.

142.06 *Discharge Of Patients.* When the superintendent of the hospital *or the attending physician* is of the opinion that a county patient is cured, or no longer needs treatment, or cannot benefit thereby, he shall discharge the patient. *The county judge in case of treatment in the county may discharge the patient whenever he is satisfied as to said facts.* If the patient is unable to travel alone, *and provision therefor has not been made under section 142.05,* the superintendent *or physician* shall notify the county judge who shall appoint some suitable person to bring the patient back. Such person shall receive expenses and compensation as provided in section 142.05.

142.07 *Hospital Charges.* (1) The Wisconsin general hospital shall treat patients so admitted at rates based on actual cost as determined by the board of regents of the university. Payments made by such patients shall be credited to their account. Patients may be admitted without certificate, but the cost of their care shall not be a joint charge against the state and county wherein he has a legal settlement, except such patients are admitted in an emergency pending action of the county court. If the court grants the application the charges against state and such county shall date from his admission. An emergency shall include cases where, by reason of unforeseen physical conditions, a patient is detained in the hospital longer than anticipated and is thereby financially unable to bear the expense of the treatment.

(2) No compensation shall be charged against or received from any patient by any officer of or person employed by the hospital other than the compensation provided by the board of regents of the university.

142.08 *Reports; Payment of Charges.* (1) The net cost of caring for a certified patient *at the Wisconsin General Hospital or Wisconsin Orthopedic Hospital For Children* shall be paid one-half by the state and one-half by the county of his legal settlement. The county board may in its own name collect from such patient the total net cost of such care, and after deducting its share of the cost of such care pay the balance so collected to the state.

(2) The board of regents of the university shall file a verified monthly report with the secretary of state, containing an itemized statement of the account against each such patient naming the county. The secretary of state shall audit the same and issue a warrant against the state treasurer for the proper amount. The state treasurer shall thereupon transfer such amount from the general fund to the appropriation provided in subsection 20.40.

(3) On or before October first in each year the board of regents shall file with the secretary of state a statement setting forth in detail the account of each certified patient during the fiscal year ended on June thirtieth next preceding.

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(4) The secretary of state shall thereupon certify to each county one-half the amount paid by the state for each such patient from that county, and one-half the total amount so paid which last amount shall be certified, levied and collected with the general state taxes.

(5) The expense of treatment of patients in other hospitals under this chapter shall be paid by the county treasurer upon certificate of the county judge, who shall be satisfied as to the correctness and reasonableness thereof.

Outagamie County Medical Society Sponsors Early Diagnosis Campaign

During the last two weeks in April the Outagamie County Medical Society in conjunction with the Appleton Woman's Club sponsored the Early Diagnosis Campaign conducted by the Wisconsin Anti-Tuberculosis Association. Through this organization of forces, the Medical Society was able to carry on a far-reaching and effective piece of work. These dozens of people working together were better able to reach a larger proportion of Appleton's population than one or two workers could hope to do.

The representatives of the Appleton Woman's Club, the City Nurses, the Principal of the Senior High School and Vocational School assisted materially in the campaign.

This working group in turn enlisted the cooperation of the Appleton members of the County Medical Society and twenty-six physicians carried on the examinations.

A committee of four from the County Medical Society organized the members into eight teams of three members each,—two members acting as substitutes to fill in when other members could not be present. One member of each team was appointed captain and he was held responsible for his team,—all incidentals pertaining to such a campaign, such as talks before the Senior High School and Vocational School, purchasing of supplies, arranging of the schedule for examinations, was handled by the committee.

The schedule arranged for each team to work for two hours a day. Thus four teams worked from 8 A. M. to 5 P. M. The following day the next four teams.

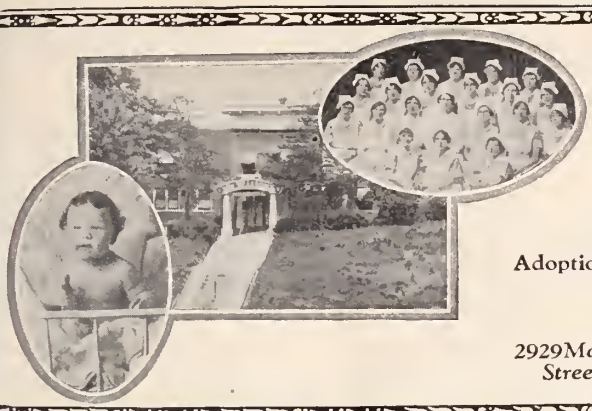
The preliminary examination as to history, temperature, pulse, weight and height was done by the nurses and recorded on card records similar to those used by W. A. T. A. The student with his record was then ready for his or her examination.

A total of 729 students were examined. From this group of 729 students, 38 were re-examined. Twenty of this number were given old tuberculin and thirteen had x-ray examinations made of their lungs. Nine cases of tuberculosis in various stages were referred to the family physician and to those interested in tuberculosis in Outagamie County.

The results of the examinations are to be found in the accompanying chart.

	Appleton High School	Vocational	Others	Total
Number examined	508	215	6	729
Re-examinations made	20	18		38
Referred for other Lab. Exams.	14	2		16
Advise Vaccination	100	54		154
Referred to family physician	210	92	4	306
Contact cases	5	4		9
Apparently normal	237	89	1	327
Defective teeth	29	34		63
Diseased tonsils (cervical)	95	46		141
Enlarged glands	2			2
Goitres	29	7		36
Goitres under treatment	5			5
Acute bronchitis	4	4		8
Anemia	5	3		8
Referred to nose and throat specialist	23	7		30
Heart Disease	8	5		13
Skin	38	8		46
Underweight	9	3		12
Obesity	2	2		4
Posture (faulty)	12	8		20
Were given Old Tuberculin	11	8	1	20
X-ray	6	6	1	13
Old Tuberculin Reaction	Pos. 1		Pos. 1	2
Ref. to family physician re-examination	13			13
Final Diagnosis re-examinations:				
Presumptive Tuberculosis	3			3
Suspected Tuberculosis	1	2		3
Quiescent Tuberculosis			1	1
Arrested Tuberculosis	1	1		2

Tuberculin tests were given to the thirteen lung cases and two of them gave positive reactions. The x-ray findings varied somewhat from the tuberculin tests. Tuberculin tests like all laboratory aids to



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diagnosis must be interpreted wisely. Tuberculin testing, as a diagnostic sign, has some practical value—a negative reaction must be considered as valuable as an aid in diagnosis.

The Medical Society have taken the responsibility for all clinics in the future. These clinics will be carefully planned and well organized. The members themselves besides getting closer in touch with the people of the community are better able to guide them in the problems of health.

THE COST OF THE CLINIC

Materials and supplies	$ 54.92
To Doctors	380.68
To X-rays	142.00
	$577.60

The $380.68 derived from the clinic has been placed to the credit of the County Medical Society, to be used as the society deems advisable.

Council Approves Plan for Providing Secretaryship for Wisconsin Hospital Association to Further Joint Interests

A proposal by officers of the Wisconsin Hospital Association that the Secretary of the State Medical Society act as Secretary of the Hospital Association to join in actuality what are already the joint interests of the medical profession and hospitals of the State, received the favorable action of the Council in May. As result the Wisconsin Hospital Association, not denominational, elected Mr. George Crownhart as Secretary for the coming year. The letter of Mr. Crownhart to the Hospital Association, upon which the action was based, follows:

When Doctor Coon was President of the Wisconsin Hospital Association, I suggested to him that the Wisconsin Medical Journal would be happy to devote some space in each issue to the proceedings and news of the Wisconsin Hospital Association. It is my understanding that this was approved by the Board of Directors but the matter drifted without any definite arrangement being made. Several months ago I again broached the matter to you.

Frankly, what I had in mind in making this proposal were two objectives:

1. To broaden the scope of the Journal so as to include in more prominent position the hospital activities of the state, having in mind that the alignment of physician and hospital was becoming a more nearly identical one in facing the joint problems of the future.

2. To secure, if possible, increased advertising revenue on the basis of the Journal being the publication medium of the Wisconsin Hospital Association. At the present time the Journal is not quite self-supporting. Because of high standards we are limited in securing additional copy from pharmaceutical houses. If the Journal were the medium of the Hospital Association I think we could secure some advertising of hospital supply houses, which copy is rarely secured at present.

To this proposal you subsequently countered with the suggestion that I, personally, become the Secretary of the Wisconsin Hospital Association in addition to making the Journal your official publication. This would mean, if I understand correctly, that I would do the regular secretarial work of the Association and, as we found it possible, to inaugurate such services to the member institutions as might lend themselves to ready accomplishment by reason of the association of offices with those of the State Medical Society (such services subject to approval of your Board of Directors).

Because of the heavy program of future activities now assumed by the State Medical Society, its Councilors are reluctant to add further work in its executive office. Subject to a year's experience, however, they have expressed themselves as willing that I should accept the position if that should be the wish of your Board of Directors. They appreciate, as do I, that many of the problems of physicians, as a group, and of hospitals, as a group, are of an identical nature and that others overlap.

I am reminded that it was the efforts of this Society at this legislative session that secured modification of a pending measure that would have instituted what would amount to licensure by the State Board of Control; that our efforts to modify proposed legislation that would affect malpractice actions adversely may be said also to affect hospitals; that the eight-hour day bill without hospital exemption was called to your attention as result of our legislative work.

In the interest of a clear understanding I wish to state here:

1. Assuming that you continue your present compensation of the Secretary, such compensation will be to the State Medical Society and not to myself.

2. The term would be not to exceed from year to year and at all times the Secretaryship may be summarily ended by your Board of Directors.

3. Fully appreciative of the high personal compliment you convey to me in making the suggestion that I assume your Secretaryship, it is neither sought by this Society nor myself, but welcomed only as the future may prove it to be the means of joining in actuality what are already the joint interests of both organizations.

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Medical Course At least two years of college work, including English, foreign language, physics, chemistry and biology, are required for admission. The course requires at least four years for completion. During the first two of these years the work lies chiefly in the basal medical sciences outlined above. The third year of the course is devoted to didactic and practical instruction in the wards and out-patient department of the Wisconsin General Hospital. The fourth year of the course is devoted to practical instruction under the supervision of preceptors in the Wisconsin General Hospital and in affiliated institutions.

Courses in Nursing Courses in nursing are offered in the School of Nursing affiliated with the medical school. A residential course of 32 months is offered in the Wisconsin General Hospital to those who have completed a semester of specified work in the College of Letters and Science. This course leads to a certificate of graduate nurse. A residential course of 27 months is offered to those who have completed three years of college work in specified subjects either in the College of Letters and Science or in the Department of Home Economics. These courses lead to a certificate of graduate nurse and to a B. S. degree.

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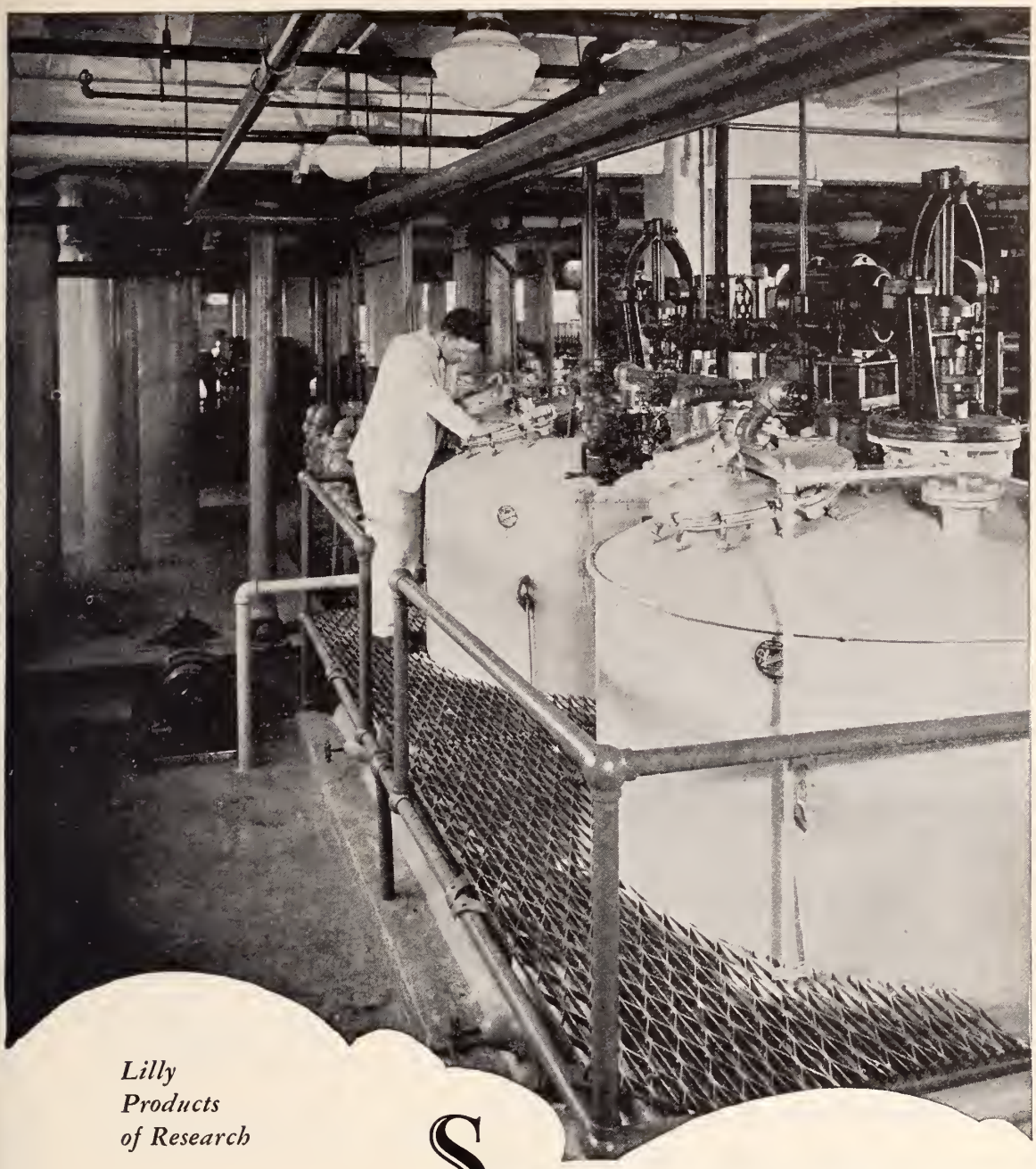

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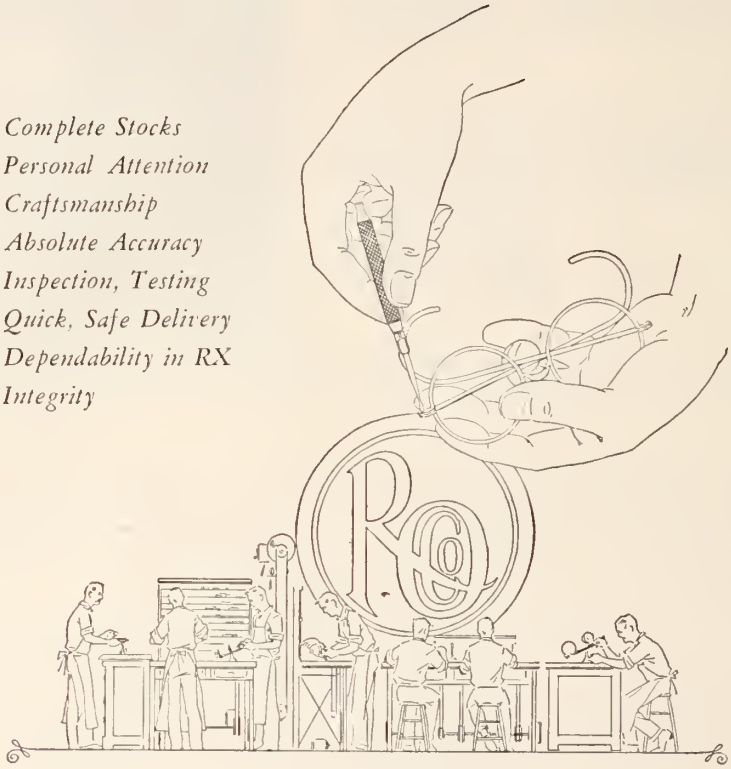

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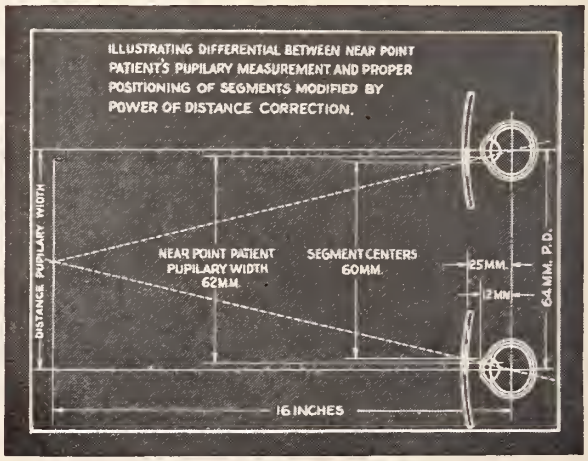

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The Wisconsin Medical Journal

Volume XXX JULY, 1931 No. 7

Introduction to Symposium on Gastroduodenal Ulcer; Its Provocation, Prevention and Treatment*

Discussion is restricted to the practical aspects which establish therapeutic principles and indicate how methods based upon these principles can be utilized to satisfy the requirements of individuals.

Chronic gastroduodenal ulcers develop spontaneously only in man. Attempts of many investigators to induce comparable lesions in lower animals by injuring the walls of the viscera or by interfering with the blood and nerve supply thereto have failed. Moreover, incisions into the walls of these viscera, suitably made and closed in operations upon fairly robust human beings, heal notoriously well. Consequently, more than local influences are responsible for the development of chronic peptic ulcers.

These facts warrant the following definition: Chronic gastroduodenal ulcers are the conspicuous lesions provoked by sundry local, regional and systemic disorders which are peculiar to human nervous and physical organization.

Direct and comparative clinical and pathologic examinations and experiments designed to induce comparable regional and systemic disorders are the sources from which information requisite to more efficacious therapy can be obtained.

Consideration of cutaneous ulcers proves the factors constantly operative in the histogenesis of chronic superficial ulcers to be deficient blood supply and irritation which are traceable to local, regional and systemic pathogenic influences. Deficient blood supply is the more significant factor. It alone can introduce an ulcer and is constantly influential in protracting healing, thereby imposing chronicity. The persistence or recrudescence of an ulcer is the most pernicious form of irritation because consequent edema and progressive cicatrization impose increasing deficits in the blood supplied to the crater of an ulcer. Delayed healing of acute ulcers produces subacute ulcers, and protracted healing of subacute ulcers produces chronic ulcers. Prevention of chronic ulcers is attainable through protection of skin against irritation and deficits in blood supply and by promoting the healing of acute and subacute ulcers. Effective treatment of chronic ulcers necessitates removal of surrounding cicatrix, re-establishment of an adequate blood supply and protection of healed area from subsequent irritation.

A direct study of acute, subacute and chronic gastroduodenal ulcers removed at operation and postmortem, and of clinical manifestations and correlated barium x-ray observations must be supplemented by knowledge gained from similar comparative studies of cutaneous ulcers in order to fill the gaps in accurate information that result from inability to see the formation of acute and the evolution of subacute and chronic lesions of gastroduodenal mucosa. The evidence thus obtained is definite.

The factors constant in the histogenesis of acute gastroduodenal ulcers are deficient blood supply and irritation. Acute ulceration is not infrequent but the majority of such ulcers heal rapidly and scarlessly. The influences that protract the healing of acute ulcers and lead to subacute and chronic ulceration are hyperperistalsis and spasm.

Hyperperistalsis and spasm, commonly accompanied with hypersecretion, increase the deficits in blood supply and augment physical and chemical irritation. Hyperperistalsis, the most potent pathogenic influence, quite constantly precedes and is responsible for the acute ulcers destined to become subacute and chronic, although hyperperistalsis does not always cause ulceration. In other words, those insusceptible differ from those

* Symposium presented before 89th Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, September 11, 1930.

susceptible to chronic ulcers either in their tolerance of hyperperistalsis and its common associates hypersecretion and spasm or hyperperistalsis and spasm with the resultant intra-gastroduodenal hypertension is more forceful in the susceptible.

Prevention of chronic gastroduodenal ulcers, since susceptibility and insusceptibility of individuals may be indeterminable, depends upon eliminating the local, regional and systemic influences that provoke hyperperistalsis. Treatment of chronic gastroduodenal ulcers includes the same principles proved effective in the treatment of chronic cutaneous ulcers plus the prevention of subsequent hyperperistalsis and additional ulceration.

Chronic ulcers affect the lesser curvature of the stomach proximal to the antrum, the antrum, pylorus and adjacent segment of the duodenum. It is necessary to consider the normal structure and function of the stomach and duodenal bulb, and how their functions are regulated; to recognize how their peristalsis is raised above wholesome limits in morbid states; and to review experimental data in order to appreciate the nature and applicability of therapeutic principles thereby indicated and to evaluate those of established efficacy.

Summary of Gastrointestinal Structures with Reference to the Production and Regulation of Gastroduodenal Functions

By EBEN J. CAREY, M. D.
Professor of Anatomy
Marquette University School of Medicine
Milwaukee

GASTROINTESTINAL TRACT AS A WHOLE

Mucosa. The lumen is covered by simple columnar epithelium that varies in its cellular structure in stomach, intestine and colon. Its functions are protection, secretion, absorption, and excretion.

Muscularis. Carey (1) found the strands of gastrointestinal muscles to be spirals, left-handed helices, if viewed caudalward. The two sets of fibrils composing the muscularis mucosae and the inner muscular layer are closely wound spirals. The outer (longitudinal) layer is a loosely wound spiral. Vermicular motions are produced by reciprocal relaxation and contraction of the outer wider muscle spiral and the inner closer spiral. A propulsive peristaltic wave is composed of a cephalic (ischemic) contraction and caudal relaxation. It is a response to a stretching stimulus within the lumen. Propulsive peristalsis declines inconstantly from cardia to anus, constituting the gastrointestinal gradient which produces the timely expulsion of egesta. Less forceful squeezing or segmentation, digestive peristalsis, is a response to more restricted stimulation. It produces kneading in to and fro motion but not propulsion.

Nerves. The intrinsic nerves of the gastrointestinal tract form local reflex arcs. Non-medullated fibers form ganglionic plexuses, a myenteric (Auerbach's) plexus within the muscles and a submucous (Meissner's) plexus sending fibrils to the blood vessels and lymphatics and to the cells (and glands) of the mucosa. The extrinsic nerves are derived from the vagus and the splanchnics. Intrinsic innervation so regulates digestive activities as to make the tract an automatic organ which, however, is subject to further integration, and in man sometimes to disintegration through the extrinsic nerves from the central and organic nervous systems.

Blood Vessels and Lymphatics. Arterial branches enter the subserosa and form subserous and intramuscular plexuses external to the submucosa. Other arterial branches penetrate the submucosa, enter the mucosa, form an abundant capillary network terminating in venules. Veins form mucous, submucous, muscular and subserous plexuses and drain into the portal vein. Lymph gland tissue in the mucosa is widely distributed but is larger, more constantly located and more commonly contains germinal centers in the ileum and colon. Lymph vessels originate in all layers; those in the mucosa are the more significant in this discussion. The primary vessel, close to the epithelium,

is blind, and from it radicles, uniting with adjacent radicles, form channels that extend peripherally. They may unite with others to form a plexus in and about the glands of the mucosa or pass directly to the plexus within the submucosa. Some of the lymph vessels pass into solitary collections of lymph gland tissue or into solitary or agminated follicles which act as filters. Thence the vessels that have originated in the mucosa and submucosa pass with those originating in the muscularis and subserosa to become the afferent vessels of the adjacent mesenteric and of the regional retroperitoneal lymph glands. Thereafter the flow is to the receptaculum chylae.

Ulcers begin acutely because of superficial loss of substance from trauma, from local ischemia, and become chronic only when the blood supply is impaired. Hence the significance of the location and distribution of arteries, veins and lymphatics.

Arteries. Occlusion of an intrinsic artery will not cause necrosis because of an effective collateral circulation. If, however, in addition to occlusion, local inflammatory reaction produces sufficient swelling to obstruct collateral branches, limited necrosis occurs. Artero-spasm, as in Raynaud's disease, might have such an effect but it is unlikely that the spasm would be limited to a group of adjacent vessels in the submucosa and thus produce a local necrosis. If it involves larger vessels in the mesentery or within the visceral wall, the necrosis would extend to more than a focus in the mucosa. Ischemia of the entire visceral wall occurs when peristaltic contractions are forceful, but unless this should foster thrombosis, it is harmless. Protracted spasm, on the other hand, causes corresponding hyphemia or even ischemia.

Veins. Occlusion of veins so as to produce focal necrosis of the mucosa alone is unrecorded. Chronic passive congestion consequent upon portal obstruction does not produce gastroduodenal ulceration.

Lymphatics. Localized lymphedema may occur in the mucosa but is not a recognized cause of necrosis. Inflammation in the solitary and agminated follicles does lead to ulceration, and conceivably, inflammation in and about the solitary lymph gland units might produce the same effect in gastroduodenal mucosa. Bacteria pass through the mucosa more freely when its surface is disrupted than when it is not. Lymphadenitis of the subacute, non-specific type, particularly when pronounced in regional glands, is suggestive of ulceration but not always a proof thereof.

Stomach. The first segment of the digestive canal wherein food is retained for longer intervals and in which active digestion and some absorption occur, consists of cardia, fundus and pyloric portion.

Mucosa. A thick coat of more highly specialized cells which are correspondingly of less structural stability provides the protective covering. Pits can be seen on the surface and from them the gastric glands extend peripherally. The glands consist of a mouth (pit or crypt), a neck and a fundus. In the specific secretory portion, the neck and fundus, are found two varieties of cells: the chief or peptic cells, and larger acid oxyntic cells. The surface or protecting cells are high columnar, line the mouths of glands and cover the areas between the pits.

According to Radasch (2) the acid cells in an adult human stomach extend 63.09% of the distance from cardia to pyloric orifice along the lesser curvature; along the greater curvature, 81.55%; along the middle of the ventral surface, 76.48%; and along the middle of the dorsal surface, 80.54% (Fig. 1). In cardia and fundus the glands are chiefly tubular structures with many acid cells in the epithelial lining, whereas, in the pyloric end the glands are of the branched tubular type and few acid cells are present in the epithelial lining.

Whether the parietal cells secrete chlorin in the form of an organic base chlorid and hydrochloric acid is subsequently liberated (3) or the acid is present in the primary secretion (4), the fact that the parietal cells are fewer in the ulcer-bearing area indicates that necrosis and digestion of these cells are not the initiating lesion. Moreover, resections of the stomach sufficient to reduce acid formation materially must extend quite to the cardia.

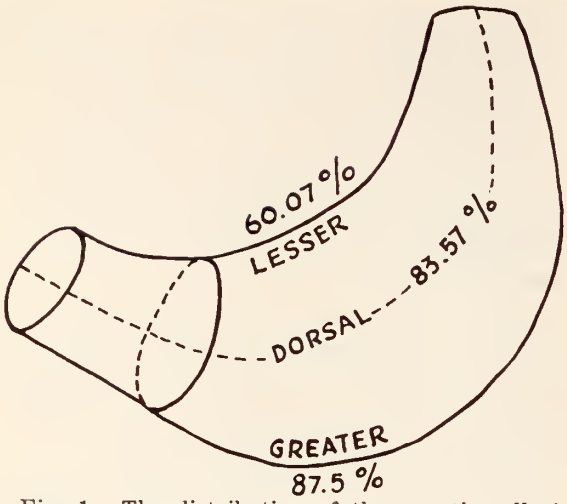

Fig. 1. The distribution of the oxyntic cells in the gastric mucosa is indicated in percentages of the distance from the cardio-oesophageal junction along the lesser, dorsal and greater curvatures.

The gastric mucosa and submucosa in the cardiac portion and that extending along the lesser curvature to and including the pyloric portion (Fig. 2) is more firmly fixed to the tunica muscularis than is the mucosa and submucosa in the fundus and along the greater curvature.

In an empty stomach the mucosa and submucosa are thrown into rugae which are longitudinally linear along the lesser curvature and longitudinally convoluted along the greater curvature. When a stomach is distended, the rugae disappear. This arrangement serves two purposes: It provides the stomach with a wide range of storage capacity, yet it retains a more constant arrangement of the mucosa along the lesser curvature, including the cardia and pylorus, the portions wherein the more severe mechanical work is done and which, be it noted, compose the gastric ulcer-bearing area.

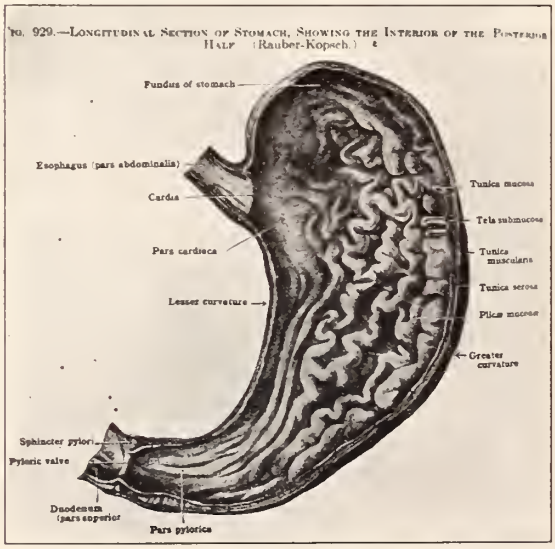

Fig. 2.

Inflammation of gastric mucosa may precede and quite constantly is associated with ulcer. Unless provoked by corrosive irritants, Schmidt (5) found the surface epithelium to be better preserved in inflammatory states than the glandular cells, but it tends to undergo transformation so that the cells come to resemble intestinal epithelium. A similar metaplasia occurs in the region of gastric ulcers and by some is supposed to be a factor in the genesis of ulcer.

Muscularis. Three layers form the muscular wall: outer, longitudinal; mesial, circular; and inner oblique. The outer longitudinal coat is relatively thin; its fibers are most numerous along the lesser curvature and at the two orifices (6) (Fig. 3). The mesial circular or close spiral layer is the thickest, particularly at the cardia and pylorus where it forms the sphincters. The innermost oblique layer is thickest at the cardiac end.

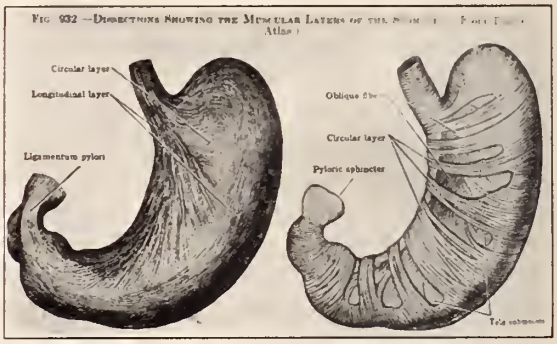

Fig. 3.

The muscular arrangement should be noted by operators. Gastro-enterostomy stomas should be made no longer than necessary so as to avoid undue transection of the circular fibers, the most important layer. Conversely plastic operations at the distal end should transect widely enough to relieve spasm, perhaps the pyloric band alone, sometimes through the entire antrum. The

line of division in making resections should be perpendicular to the long axis of the stomach so as to parallel the fibers of the circular coat, thus facilitating recovery of a sphincteric control of the artificial outlet and imposing the least impairment of automaticity in the portion retained.

Nerves. Extrinsic gastric nerves are derived from sympathetic trunks, splanchnics and vagi. They enter the stomach wall with the arteries, accompany their branches and are distributed to Auerbach's intramuscular and to Meissner's submucous plexuses. Fibrils from the myenteric plexus extend to the tunica muscularis, from the submucous plexus to the vascular walls and to the secreting epithelium. They transmit motor, vasomotor, secretory and sensory impulses.

Whether, as has been supposed, the vagi transmit pressor and the splanchnics depressor impulses or whether both types of impulses are transmitted by either set of nerves, their chief obligations are to maintain and to restore automatic regulation of motion, tonicity and secretion.

Vessels. The course of blood vessels into and through the gastric wall differs immaterially from that already described for the gastrointestinal tract as a whole. Definite peculiarities in vascular organization leading to ulcer-producing ischemia are unrecognized although it is known that anastomosis of intramural arteries is freer at the cardiac end than the pyloric and along the greater curvature than the lesser. So, too, there is no proof that such ischemia results from spasm of mucosal vessels. The origin, course and distribution of lymph vessels in stomach and intestinal tract are quite the same. Those that drain the distal portion of the stomach empty into glands in the omentum along the greater curvature which are particularly prone to irritation and subacute inflammation in the presence of ulcer.

DUODENUM

Mucosa. The structural units are villi, Lieberkühn's glands, placed internal and Brunner's glands placed external to the muscularis mucosae. Columnar cells cover the villi, extend into Lieberkühn's glands in which are also goblet and granular (Paneth) cells. Brunner's tubulo-acinar glands are related to the pancreas. Secretions of duodenal cells are alkaline and combined with bile and pancreatic juice normally neutralize acidity of gastric contents soon after its ejection into the bulb.

Muscularis. Two coats of the muscle coat, outer (longitudinal) loose spiral, inner (circular) close spiral are strongest in the bulb and there exert the most forceful peristaltic contractions. This is the head of the entero-colic portion of the gastrointestinal gradient. Incomplete distal intestinal obstructions, including artero-mesenteric duodenal occlusion, provoke an increase in the force of contractions of the duodenal bulb which, in turn, may provoke gastric hyperperistalsis. Thus the duodenal bulb, the lesser curvature and pyloric portion of the stomach, which comprise the entire ulcer-bearing area, are the portions where contractions are the most forceful and mucosal trauma the most severe.

Nerves. Origin and distribution of nerves to and from myenteric and submucous plexuses is directly comparable to those in the stomach. Normally the activities of the duodenum are regulated automatically. Operations upon the duodenum should be designed to preserve or to restore its neuromuscular balance and should avoid, so far as feasible, transection of the fibers of the stronger, more powerfully propulsive inner coat.

Blood Supply. In general the intramural course of blood vessels has been described. Two peculiarities are perhaps noteworthy. According to W. J. Mayo (6) downward traction upon the duodenum produces an anemic spot in the anterior surface of its first portion attributable to obstruction of the supra-duodenal artery which supplies this area. Wilkie's (7) arterial injections demonstrate a relatively avascular zone in the posterior wall of the first inch of the duodenum. It is questionable whether the normally restricted blood supply in these two areas, accentuated perhaps by hyperperistalsis, plays a role in ulceration.

Lymphatics. Origin and disposition of lymph vessels differs little from descriptions already given. Lymph flow from bulb is in

part to glands in the peri-pyloric region which commonly become subacutely inflamed in duodenal ulcers. The largest amount of lymph tissue within intestinal mucosa, except in the terminal ileum, is in the upper duodenum. Extensive confluent deposits containing some germinal centers and penetrated by ducts of glands occur in the deeper stratum of the mucosa. Inflammation in this lymph tissue with consequent edema might account for acute ulceration.

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Functions of the Gastrointestinal Tract with Special Reference to Ulcer-Producing Gastroduodenal Malfunctions

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The entire gastrointestinal tract for the moment will be viewed as a single organ. Its prominent functions are to receive, to store, to propel and to expel ingesta and during transit so to manipulate them mechanically and to alter them chemically that digestion will permit of absorption of wholesome products. Indigestion and irritation promote the expulsion of useless and unwholesome material.

Muscular contraction and relaxation, the secretion, excretion and absorption by mucous membranes and the added secretions of liver and pancreas are regulated automatically under usual conditions. Suitable pressor and depressor impulses arise from the physical, chemical and thermal characteristics of the ingesta and in the intrinsic myenteric and submucous nerve plexuses. Vermicular action, largely the result of rhythmicity inherent in the gastrointestinal muscularis, the rate of secretion, absorption and excretion are co-ordinated. In consequence the motor responses retard the passage of ingesta in some segments of the canal, hasten the progress in others so as to facilitate digestion and absorption and also to prevent stagnation in any segment. The net result is progress from cardia to anus. This mechanism is termed the gastrointestinal gradient because of its comparability to the flow of a stream that widens at intervals to form shallower lakes through which the current is less rapid.

When the onflow of contents is unduly delayed; e. g., by incomplete active or passive obstruction in any segment, the first segment proximal to the obstruction is impelled to increase the force of its propulsive peristaltic contractions in order to preserve the gradient and thereby safeguard nutrition. Should the first proximal segment be or become incompetent to provide requisite compensatory propulsive power, other segments successively more proximal are stimulated to hyper-activity. Thus delays in distal segments may result in hyperperistalsis in duodenum, finally in stomach, and, if this compensatory activity be inadequate to propel the ingesta and added secretions, relief is afforded by nausea and vomiting. Sometimes instead of progressive retro-activation of successive segments proximal to the obstruction, the duodenum and stomach (or the stomach alone) are directly affected and respond with hyperperistalsis, hypersecretion and an earlier excitation of pain, nausea and vomiting.

In addition to the automatic regulation of the digestive tract, its gradient, essential to nutrition, is further controlled by pressor and depressor impulses originating in central and organic nervous systems and delivered through the extrinsic nerves and by internal secretions. Several means, some as yet unknown, are provided to safeguard the natural gradient against upsetting influences and to foster its restoration once it has been

upset. Presumably a normal gradient is obtained if the automatic regulation is effective. Consequently, therapeutic obligations are to maintain or to re-create its efficacy.

The influences of the subsidiary regulators are, however, not always beneficial. Morbid emotionalism can result in a delivery of unwholesome stimuli through the vagi. A transient excess, either of pressor or depressor impulses, will disrupt the gradient by inco-ordinating motor and secretory responses temporarily, or, if long continued, permanently. Similar consequences result from protracted instability of the organic nervous organization sending untoward impulses through the splanchnics, also from continued or recurrent endocrinal imbalance. Moreover, the muscles of one or more segments can become transiently or permanently inactivated through fatigue and exhaustion. The intrinsic neuro-muscular automatic regulator may be supersensitive. More than one factor can, therefore, be instrumental in deranging the normal automatic regulation of the gradient so that not only may recognition of the cause or causes be difficult but also the elimination thereof can be impossible.

Although the stomach and duodenum are structurally dissimilar and will be discussed separately, the stomach and duodenal bulb are so co-ordinated functionally that they form a digestive unit.

STOMACH

Storage. The walls of an empty stomach are apposed save for the air bubble in the top of the fundus. Ingesta after entering through the cardia tend to pass along the lesser curvature toward the pylorus and out through the pylorus if it be relaxed. It is the pathway of least resistance, the stomach street of Waldeyer. After the pylorus closes, more or less solid food passes backward along the greater curvature, and successive ingestions are deposited in layers. The musculature of the fundus adapts its walls to the volume of contents by its property of plastic tonus which makes possible the taking of large quantities of food at relatively long intervals.

Movements. Excepting hunger contractions the purpose of gastric movements is to soften more solid food by compression and rubbing (manipulative or digestive peristalsis), to mix it with digestive juices and to propel it (propulsive peristalsis).

Immediately after a meal has been eaten the pressure in the fundus is low and contraction waves, if any, are shallow. Vigorous contractions begin at the incisura and sweep toward the pylorus at a rate of two or three to the minute. At first shallow, they deepen and finally almost or entirely obliterate the lumen. They reach the pyloric sphincter as separate waves or the whole pyloric portion undergoes a kind of systolic contraction. From the incisura downward, pressure, at times quite considerable, is exerted upon stomach contents and equally upon mucosa and slightly less upon submucosa and the balance of the gastric wall. As digestion proceeds and the stomach is emptying, the peristaltic waves begin nearer and nearer to the cardia. After the stomach is empty they involve the fundus and are recognized as hunger contractions, each series of contractions giving rise to a recognized sensation, the so-called hunger pain.

Propulsion. At intervals the pyloric sphincter relaxes and portions of chyme are expelled from the stomach. The mechanisms responsible for pyloric relaxation are not understood. It is not the force of antral contractions though this is considerable at times. The theory of acid control is questioned because alkaline or neutral fluids may pass quite readily into the duodenum. Since liquids pass out more readily than solids, perhaps the consistency of stomach contents, reduced by digestion, initiates local opening reflexes. Many believe that the opening of the pylorus is due to a normal inhibition preceding gastric expulsive peristalsis as distinguished from digestive contractions. Recently it was found that raw protein present in gastric contents greatly increases pyloric tonus. Relaxation and opening of the sphincter might then result from a disappearance of this stimulus as the protein is digested. This factor is eliminated when the contents are protein-free and

then emptying is hastened. Evidently more than one influence is active.

Secretion. Gastric juice is secreted normally in cephalic or psychic, gastric and intestinal phases. Sight, smell and taste all stimulate reflex secretion by impulses delivered through the vagi if appetite be present. This appetite juice initiates gastric digestion. Since the enjoyment of eating is transient, the psychic phase is of short duration. During the following gastric phase, secretion is stimulated mechanically by distention of the stomach and chemically by substances in food called secretogogues, particularly abundant in meat and meat extracts. The gastric phase varies from one to six or eight hours according to the quantity and quality of the ingesta and the thoroughness of mastication. Gastric secretion is further stimulated by the action of substances formed in the intestine, the nature and purpose of which are unknown. Ivy transplanted a stomach pouch into the breast of a dog where its glands secreted at proper intervals. This demonstrates the existence of humoral stimuli.

Hypersecretion, incorrectly called hyperacidity, is commonly a characteristic of all but late phases of peptic ulcer and pylorospasm. The likely causes are disturbances in the nervous, secretory and motor mechanisms. Nerve impulses are of lesser import because administration of atropine and division of the vagi are often ineffective. Direct chemical irritation from egesta or perhaps excitation from hormones might overstimulate the gastric glands. Pylorospasm is certainly provocative. Food is thereby retained longer in the stomach, hyperperistalsis is aroused, secretogogues act for a longer interval.

DUODENUM

Only the bulb will be considered, which, be it recalled, is functionally a part of the stomach rather than the intestine. It collaborates with the pyloric sphincter; it receives and holds chyme for a short period. Its relationship to the bowel is proved by the fact that from the bulb arise intestinal peristaltic waves. Another feature may be extremely significant in relationship to ulcer. Reversed digestive peristalsis as well as propulsive peristalsis is normal in certain segments of the digestive canal. Formerly it was supposed to occur only in the proximal colon, but reversed peristaltic movements are known to be normal in the duodenum. Regurgitation of alkaline fluids into the stomach, the duodenal reflux, at the end of periods of gastric digestion will reduce acidity and perhaps inhibit gastric secretion. The duodenal reversed peristalsis, if provoked by irritations, including ulcer, may be unusually vigorous and sweep back over the stomach.

Causation of chronic gastroduodenal ulcers. An acute ulcer is the first step. Delayed healing of this lesion produces subacute, finally chronic, ulcers. Explanation of the evolution of chronic ulcers must include the initial injury which destroys an area of mucosa and subsequent irritation and diminished blood supply which protracts healing.

If the local action of ingested corrosive poisons or the excretion through the mucosa of irritants in the blood be eliminated as infrequent causes of acute ulcer, physiologists can account for the initial lesion by physical injury. Two factors then are potent. Bruising of the mucous membrane and possibly of the submucosa by hyperperistalsis, and spasm of pylorus or antrum or bulb exerting intolerable pressure against resistant food. Necrotic portions of mucosa are rapidily digested, removed and an acute ulcer is formed. Irritation of the ulcer base is continued by the acid gastric juice, intensified by local spasm (revealed in the incisura) and by the added injuries inflicted by hyperperistalsis in proximal segments awakened by this spasm, pylorospasm, antraspasm, or bulbar spasm which through partial obstruction upset the gastric gradient. Hyperperistalsis provokes recurrent antraspasm, pylorospasm and probably bulbar spasm; all produce protracted ischemia which favors thromboses. Thus the initial lesion and protraction of its healing are explained. Physiologists have also disclosed some at least of the causes of hyperperistalsis and spasm without which acute ulcers do not become chronic.

Therapy. Reasons for effective measures can be stated quite definitely from a physiologist's viewpoint.

Prevention. The majortiy of acute and virtually all of the subacute and chronic ulcers are caused by hyperperistalsis and spasm. Obviate hyperperistalsis and there would be left a small proportion of acute ulcers and these heal rapidly.

Treatment. The basis of success is a restoration of the gastrointestinal gradient accomplished by rehabilitation of the automatic regulation of the gastrointestinal activities whereby motion, secretion and absorption are so co-ordinated as to promote nutrition.

The cause or causes of hyper-peristalsis must be eliminated. Attempts to treat gastroduodenal ulcers as local lesions by the employment of routine measure which do not include a recognition of regional (cholecystitis, appendicitis, distal partial obstruction, etc.) and systemic (nervous instability, anemia, endocrinal imbalance, remote sources of irritants, etc.) are obviously futile and have been so proved in clinical experience.

Pathology of Gastroduodenal Ulcer

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Man alone suffers from chronic spontaneous gastroduodenal ulcer, although acute ulcers occur in other animals. Not infrequently it is a familial disease with numerous instances in the members of one or in those of successive generations.

Anthropometric. Draper recognized a distinct ulcer type of individual having a low weight-height index, an acute costal angle, a thin chest antero-posteriorly and a narrow, upper jaw.

Incidence. Ulcer occurs from a few weeks after birth to late senility with the majority between the ages of forty and sixty. Acute gastric ulcer develops slightly more often in males, chronic gastric ulcer in females and chronic duodenal ulcer appears much more often in males. Differences have been noted in the seasonal incidence and geographic distribution.

Location. Characteristic round (peptic) ulcers occur only in mucosa bathed in acid gastric juice, i. e., the stomach, duodenal bulb, distal end of oesophagus, in the jejunum following gastro-jejunostomy and in the tip of a Meckel's diverticulum when that anomaly contains the gastric type of mucosa. Such ulcers do not develop in the dome of the fundus of a stomach which is protected by an air cap nor in the achylic stomach of pernicious anemia. Action of acid gastric juice is therefore responsible for the character of the ulcer.

Distribution. Eighty per cent of gastric ulcers lie within four inches of the pyloric ring, straddling the lesser curvature or, if on one side, more commonly on the posterior surface than on the anterior. Duodenal ulcers are always in the bulb and on either the anterior or posterior surface.

Frequency. Postmortem statistics show duodenal ulcer to be about twice as common as gastric ulcer, and their frequency varies in different parts of the world. By far the highest rate is reported from the Leeds Infirmary. In four thousand consecutive necropsies one-tenth of the adults were found to have or to have had gastric or duodenal ulcer. Moynihan's reputation presumably has influenced the population of the Infirmary, and moreover one may suppose that there a more careful search is made for evidence of these lesions. Surgical statistics show duodenal ulcer to be encountered approximately four times more frequently at operation. This would imply that duodenal ulcer produces more distressing symptoms and more urgent complications than gastric ulcer.

Morbid anatomy. Gastric or duodenal ulcers may be acute or, according to the stage of repair, they may be designated as subacute, chronic, healed and recurrent.

Acute ulcers. These lesions are more commonly multiple than single and vary materially in size. Absence of induration makes it impossible to discern them from the peritoneal surface and they may escape detection even when the mucosa is exposed at postmortem if they are small and placed at the base of a fold. When a viscus is opened at operation, the ulcer usually reveals itself by the more or less active oozing of arterial blood. The healing of acute ulcers tends to be rapid and so perfect that there is little residual cicatrix, and the normal mucosa is reproduced.

Subacute ulcers. Depending upon size and depth of the lesion and the extent of inflammatory reaction, these ulcers may be seen or felt through the serosa or they may be difficult to identify when the mucosa is exposed at operation unless there is bleeding. Stippling, noted by surgeons, is not always a positive means of identification. Repair of the mucosa is faster than of the submucous structures so that when there is no obvious lesion in the serosa or mucosa, granulation tissue may still be present intramurally and can be provocative of subsequent ulceration.

Chronic ulcers. Round ulcers are not as clean cut as earlier descriptions indicated. As revealed by examination of specimens removed during operation, a fibrinocellular exudate overlies a superficial zone of necrosis of the underlying repair tissue. Efforts to effect the final phase of healing, namely, the covering of the ulcer base with epithelium, are centripetal. Ingrowths of epithelial cells over the base of the ulcer come from the hyperplastic mucosa at the periphery. Normal mucous membrane and submucous structures are not reproduced but are replaced by a thin, perhaps a single, layer of epithelial cells, firmly fixed upon a hard base which provides a meager blood supply. The ulceration produced by progressive cicatrization discloses chronic ulcers either by the visible scarring of the peritoneal surfaces or by palpation. Chronic gastric ulcers are commonly single though they may be associated with acute ulcers, the scars of healed ulcers or other open chronic ulcers. Chronic duodenal ulcers are multiple (double) somewhat more frequently.

Healed ulcers. The extent, distribution and nature of the repair tissue depends upon the size, the depth of penetration, the age and healing rate of the acute ulcer. Small, acute ulcers can heal so perfectly that the residual cicatrix is unrecognized. Penetrating and even perforating acute and subacute ulcers likewise may heal almost scarlessly, hence the belief that perforation will lead to recovery. Contrarily, scars may be present in the serosa with or without adhesions, in the intramural structures with corresponding limitation in blood supply, or in the mucosa, either singly or in combinations. After healing has occurred the relief of submucous structures from chemical irritation and the subsequent restriction in physical stresses reduce inflammatory responses, permit involution, particularly of less mature cicatrices, and contraction of the more mature. Thus a disappearance or a diminution in the size of a deformity of a healed ulcer can betoken a restoration of normal structure that may be rather apparent than real.

Recurrent ulcers. Recurrence is a re-formation of the lesion at the site of a previous ulcer and is not the development of another ulcer in mucosa hitherto unaffected. A scar of previous ulcer contributes to the recurrence. The larger the cicatrix, the greater the liability to recurrence. This is particularly true of the larger, more indurated ulcers in which the crater is covered by a thin layer of ill-nourished epithelium firmly implanted upon an unyielding base.

Summary: The foregoing statistical and morbid anatomical data approximate fact. They indicate that in a search for the causes of chronic ulcer one must not look for rare and uncommon local provocations but rather for unusual characteristics in the individuals affected. Four facts are noteworthy.

1. Gastric ulcers are most common in the antrum wherein the contents of the stomach and its mucosa are normally subjected to the greatest pressure, where the mucosa is least movable upon the underlying layers and where its circulation, especially during forceful contractions of the muscularis, is relatively restricted.

2. Duodenal ulcers are restricted to the bulb wherein the pressure is enhanced by the obstruction to on-flow of ingesta provided by the first transverse folds of the intestinal mucosa.

3. All people are quite certainly subjected to some of the untoward states that induce acute gastrointestinal ulcers but more than ninety per cent recover.

4. Both gastric and duodenal ulcers are apt to occur in individuals of low vital capacity, in those exhibiting other stigmata indicating divers constitutional weaknesses.

The main problem at hand, the chronic ulcer, has two subsidiary problems, to-wit: the provocation or provocations of the acute ulcer from which it develops and the cause or causes of the failure of that ulcer to heal permanently.

Although the tissues devitalized by the primary injury are too rapidly digested away to permit of determination of the nature of that injury, we must assume that acute ulceration can not differ widely in principle from ulceration of any exposed surface whether it be skin or an internal surface. Wherever ulceration occurs, it exemplifies the general pathological law that no lesion always is provoked by the same cause.

Local injury initiates cutaneous ulcers; e. g., the action of physical agents, such as trauma, light, temperature, or chemical agents, including bacterial toxins; also deprivation of oxygen due to local vascular lesion or spasm and bacterial or neoplastic invasion.

Given an acute ulcer its course is a matter of blood and blood supply. With blood supply intact in a healthy individual, healing promptly occurs with the least cicatrization. With local impairment of blood supply (thrombosis, vascular sclerosis or interference from scar tissue or edema); with regional impairment from vascular disease imposing sluggish circulation of the part as a whole; with general impairment from cardiovascular disease, or with impairment of the quality of the blood in anemia and constitutional diseases, healing is retarded and we have a chronic sluggish ulcer which is prone to recrudescence.

These general principles can be applied to the stomach and duodenal bulb with modifications due to the following facts. They are hollow organs, their muscular coats seldom are at rest, and, although the regulation of muscular activity is normally to an extent automatic, it is also influenced by widely variant distal factors.

We must recognize a variety of causes for the initial lesion which group themselves into toxic causes, causes of local ischemia and mechanical causes. Toxins may be elaborated at a distance and excreted through the gastric and duodenal mucosa as in superficial burns or they may be of bacterial origin and produced locally (infectious cause). Local ischemia may be produced by embolism, thrombosis, arteriosclerosis, arterio-spasm or spastic contractions in the gastroduodenal musculature—a response to disease elsewhere in the digestive tract (chronic cholecystitis, chronic appendicitis, divers incomplete entero-colic obstructions, etc.) or from vagal stimulation from more remote causes (worry, mental disturbance, etc.). Mechanical factors rarely may be trauma to the abdominal wall but are more commonly the irritation of coarse, undigested food masses crowded under pressure into the pyloric vestibule or into the bulb in a stomach or duodenum, the seat of hyperperistalsis. Judgment of the relative importance of these causal factors and of the frequence of each must be delayed.

The non-healing of persistent ulcers, in analogy with skin ulcer, is attributable to continued surface irritation, to impaired blood supply or to both. Surface irritation is constantly provided by hydrochloric acid, frequently by unsuitable ingesta and often by implantation of bacteria. Local ischemia may be induced by the reflex persistent spasm provoked, as roentgenologists have demonstrated, by the acute ulcer itself or by a protective local vascular spasm or resultant endarteritis. General anemia may be the blood factor interfering with repair.

These facts are presented among possibilities to indicate that chronic gastric or

duodenal ulcers are more than local processes and that each patient harboring such lesions must be carefully studied to establish the underlying pathogenic factors in order to determine what therapeutic measures should be employed.

Experimental Aspects of Gastroduodenal Ulcer

By FORRESTER RAINE, M. D.
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Divers local, regional and systemic abnormalities, singly and combined, have been created in herbivorous and carnivorous animals, none of which spontaneously develops chronic peptic ulcer. The evidence obtained from attempts to provoke acute ulcers and to retard their healing so that they will become subacute and chronic and thus be comparable to spontaneous human lesions is often conflicting. Nevertheless, the information helps materially toward solution of clinical problems and warrants the following generalizations:

1. No local injury that does not destroy mucous membrane will always produce ulcer.
2. No regional or systemic induced abnormality will always produce ulcer.
3. Combinations of local nondestructive injuries with induced regional or systemic abnormalities sometimes will produce ulcer.
4. Acute ulcers provoked by destructive local injuries, acute and subacute ulcers otherwise induced, tend to heal rapidly.
5. Operations that upset the gastrointestinal gradient or operations that create imbalance between acid from stomach and alkali in intestine will sometimes induce ulcer.
6. Operations that invoke hyperperistalsis by upsetting the gastrointestinal gradient and also destroy the acid-alkali balance are not only more likely to induce ulcer, but these ulcers simulate chronic ulcers more closely than those thus far induced by other methods.

The evidence accumulated in the past twenty-five years upon which the foregoing generalizations are based will be outlined and analyzed with due regard to difference between experimental animals and human beings.

LOCAL ABNORMALITIES

Direct injury. a. Cauterization of mucosa or injecting it with formaldehyde, alcohol, etc., results in a formation of an area of necrosis, size and depth proportionate to the injury. Necrotic tissue is soon digested and dislodged, forming an acute ulcer which heals promptly.

b. X-rays. Direct radiation of exposed stomach wall. Overexposure to x-rays induces a subacute inflammation of less sensitive, and necrosis of more sensitive structures resulting occasionally in a subacute ulcer which heals spontaneously, though less rapidly, than acute ulcers. Similar lesions have been provoked radio-therapeutically.

c. Infection. Feeding of virulent bacteria, e. g., streptococci, to dogs on coarse food. Rough food may cause abrasions which are contaminated, but no more promptly than if the cocci had been limited to those present in the saliva. An acute ulcer rarely results. It is uncertain that streptococci are ever a factor in the inception of human ulcer.

d. Hyperacidity. Feeding hydrochloric acid in increasing concentration up to 0.7% which is higher than can be secreted produces no ulcer and indicates that acidity alone is not a cause of ulcer, however much it may delay healing or produce ulcer-like symptoms.

Indirect injury. e. Limitation of blood supply by ligation of one or more arteries supplying stomach and duodenum, seldom produces ulcer because anastomosis of nutrient vessels suffices to provide an adequate collateral circulation.

f. Embolism and endarteritis provoked by introduction of small foreign bodies or injection of irritants into these arteries occasionally provoke acute ulcers, but neither of these procedures is comparable to human conditions.

g. Transient artero-spasm induced by pilocarpine and epinephrine leads to a formation of superficial hemorrhagic areas, but no ul-

cers which supports other evidence indicating that Raynaud's disease is not a cause of ulcer.

REGIONAL ABNORMALITIES

Alteration of normal gastric gradient introduced by gastro-enterostomy and Billroth Type II pylorectomy also compels ingesta to be propelled through stomas. Marginal ulcers have occasionally developed. Restriction of ulceration to margin of stoma proves that local provocative factors are predominant. Hyperperistalsis need not be considered. Impaired blood supply occurs in those margins wherein healing had been the less perfect and the mucosa fixed to unyielding scar tissue as upon the base of a chronic ulcer is extraordinarily vulnerable. As a rule, less perfect healing leading to marginal ulcer is attributable to faulty operative methods.

Alterations in distribution of secretions accomplished by transplantation of common duct alone and of both common and pancreatic ducts into jejunum. Acid is not neutralized as rapidly after gastric contents are propelled into duodenum. It is quite certain that the duodenal automatic regulation is also deranged by such operations, and subacute ulcers sometimes develop in the duodenum. (It is pertinent to recall that prolonged obstruction at the papilla of Vater in human beings does not induce duodenal ulcer. The secretions of Brunner's glands and the duodenal mucosa coupled with an undisturbed duodenal gradient afford adequate protection.

COMPLICATED OPERATIONS

Complicated operations altering the distribution of secretions and materially disturbing the gradient.

a. Transection of pylorus and of jejunum just distal to ligament of Treitz. The distal end of stomach is then joined to distal end of jejunum; the proximal end of duodenum is closed and the proximal end of jejunum is implanted into ileum. The automatic control of the stomach is deranged so as to produce incomplete obstruction at the pyloro-jejunal anastomosis which suffices to retard the emptying time of the stomach in spite of hyperperistalsis. The acid gastric secretions are denied the normal neutralization by duodenal contents. Chronic ulcers develop in the jejunum just distal to the anastomosis with the pylorus, which now acts as a duodenal bulb. The delayed repair of the acute ulcer and the production of a subacute or chronic lesion is a consequence of mechanical and chemical irritation. The superiority of pyloroplastic operations upon human beings which do not derange gastroduodenal automatic regulation over the Billroth I type of operation which may derange automaticity is thus explained.

a.′ After ulcers have developed in the jejunum, just distal to pyloric anastomosis, the proximal end of the jejunum is detached from the ileum and implanted near the jejunogastric union.

Alkaline secretions thus compelled to bathe the ulcer fosters more rapid healing, quite as the administration of alkalies to patients appears to promote healing of these lesions.

a.″ After ulcers have developed as in a′, a gastro-jejunostomy was performed in another series of animals which restores gastric gradient more or less completely by circumvention of pyloric obstruction but without restitution of automatic control. A portion of gastric ejecta is shunted around the ulcer.

The original jejunal ulcers usually healed, but marginal ulcers often developed at the gastro-enterostomy stoma. (Healing of the subacute jejunal ulcers was promoted by less peristalsis; i. e., reduced mechanical and chemical irritation. Formation of marginal ulcers is attributable to reduced blood supply, either because of previous operation upon adjacent viscera or as a result of inaccuracy in performing the gastro-jejunostomy.)

b. The duodenum is transected distal to pylorus but proximal to anpulla; the jejunum is divided just below ligament of Treitz; the proximal end of duodenum united with distal end of jejunum and the distal end of duodenum closed; the proximal end of jejunum implanted into ileum. This operation deranges the automatic regulation of the stomach and first portion of the duodenum immaterially, if at all, for the emptying time is unaltered. Acid gastric secretions are to some degree neutralized by the alka-

line secretions of the duodenal mucosa and of Brunner's glands.

Subacute ulcers form in the jejunum distal to the anastomosis but less commonly than in (a). The contents of the first portion of the duodenum in these animals are firmer and less completely alkalinized than in normal animals. When propelled into the jejunum, they do arouse contractions therein sufficiently forceful to injure the mucosa but in fewer animals than in (a). So, too, the less acidity retards healing in fewer animals than in (a). These observations have practical value. When transection of the duodenum is indicated in operations upon human beings, it is safer to preserve as wide a segment as feasible of the first portion of the duodenum. Not only will this conserve the automatic regulation of the stomach and duodenal bulb which, as Dr. Meek has indicated, constitutes a functional unit, but it also reduces liability to jejunal ulceration. Our clinical experience is confirmatory.

Transplants of segments of jejunum into walls of stomach.

a. Transplant of jejunum into greater curvature or fundus of the stomach with and without feeding of hydrochloric acid subjects jejunal mucosa to the traumatism of less forceful gastric contractions and action of gastric secretions at times rendered abnormally hyperacid.

b. Ulceration of transplants does not occur, showing jejunal mucosa is as resistant to physical trauma as the gastric mucosa of the fundus and greater curvature and to hydrochloric acid even when its concentration is above normal.

b′. Transplants of jejunum into lesser curvature or into wall of stomach near pylorus (antrum) subjects jejunal mucosa to the action of gastric secretions and to traumatism inflicted by the most forceful contractions of the stomach. Ulcers occasionally develop in transplants but only near their margins, where scar tissue is thickest.

These experiments demonstrate that intestinal mucosa is not vulnerable to gastric juice even when the acid is artificially increased, nor to abnormally increased trauma so long as it is adequately supplied with blood, is unfixed to rigid walls and is not handicapped by submucous cicatrices. Moreover, the evidence indicated that the reversion of gastric mucosa lying between the crypts in the stomach to the intestinal type of epithelium, said to occur in certain forms of gastritis, does not predispose to ulceration as has been alleged.

SYSTEMIC ALTERATIONS

a. Malnutrition induced by vitamin deficiency in diet has resulted in the occasional development of superficial gastric ulcers. Deficits in Vitamin A are particularly disturbing to the metabolism of normal epithelium.

b. Anemia. Severe grades of anemia provoked by injections of dogs and rabbits with pyrodin impair resistance, defense and repair, and gastric ulcers occasionally result. Anemias of high grades exist in many human beings without leading to ulcer, though seldom failing to impair digestion. Coincidence of anemia and acute ulcers would interfere with their healing and explain the instances of anemia preceding chronic ulcer and emphasize the necessity of eliminating anemia in ulcer therapy.

c. Intoxication. A specific gastric toxin is made by repeated and intraperitoneal injections of one animal with fresh gastric mucosa obtained from animals of another species. The blood serum of an animal so immunized if potent, should, when injected into another animal of the same species, cause necrosis of the corresponding cells.

Occasional superficial erosions are caused, but they heal rapidly. This explains the causes and consequences of erosions and acute ulcers attributed to nonspecific toxins; e. g., burns, bacterial egesta, etc.

d. Infections, hematogenous, lymphogenous. So-called "specific" bacteria obtained in cultures made from the base of ulcers in human beings or from the teeth or bile of patients suffering from ulcer are injected intravenously into animals. The bulk of bacteria so injected is removed by the endothelium of the capillaries in the pulmonary circuit if the injection has been made into a systemic vein, or by that in the liver and lungs if made into the portal circulation. The few escaping removal are disseminated through the systemic arteries and may be de-

posited in any capillary. A limited number might thus reach the gastroduodenal mucosa. Some presume that "specific" bacteria are nevertheless peculiarly enabled to attain position in homologous tissue and therein reproduce the lesion which they first provoked.

Acute and subacute ulcers have been recorded by several observers as having followed such injections with convincing frequency. Bacteremia, especially during intestinal digestion, is constant in healthy folk in certain phases of acute infectious processes and frequent in individuals harboring divers chronic foci of infection. Whatever be the actual incidence, the majority escape demonstrable sequellae traceable to bacteremia. Clinical experience and postmortem observation both indicate that gastroduodenal ulceration from bacteremia is a remote possibility. Cholecystitis (frequently not infectious) is a frequent factor in producing ulcer, but present knowledge would indicate that it was not through lymphogenous transportation of bacteria to stomach or duodenum.

Regional focal infections have been established in dogs' teeth and nasal sinuses by creating local injury, introducing foreign bodies and implanting bacteria which may enter blood or lymph streams or escape into the buccal cavity and be swallowed.

Acute ulcers have developed but other factors than infection have been introduced into the experiment.

ABNORMALITIES

Abnormalities created in central nervous system and in peripheral nerves.

A close relationship between disorders of nervous organization and peptic ulcers is recognized. Since chronic morbid mental states cannot be induced in animals, this most significant nervous influence cannot be investigated experimentally. Studies are limited to observation of induced central and peripheral lesions.

a. Central lesions include ablation of quadrigeminal bodies and compression of spinal cord supposed to interfere with nervous regulation of gastroduodenal activities have occasionally been followed by acute superficial ulceration. The lack of analogy with human diseases and the coincidental injuries to animals make these observations of little significance.

b. Vagi, one or both nerves have been cut in the neck, in the thorax and abdomen. Division of one vagus nerve, in so far as stomach or duodenum is concerned is without demonstrable effect. Divisions of both vagi in neck induces paralysis of the oesophagus and sometimes produces spasm of the pylorus. Division of both vagi either just above or below the diaphragm in the experience of others and ourselves is not harmful to nutrition.

It seems likely that the vagi transient in man, both pressor and depressor impulses and until definite knowledge is available, section of both nerves is as unjustified as division of one is futile.

c. Sympathetic nerves have supposedly been repressed or excited by the administration of atropine and pilocarpine. Some observers have reported a formation of acute ulcers; others recognized no effects.

The effects of drugs on robust animals unaware of what is being attempted and upon sick people hoping for relief from an ailment wherein apprehension and depression are momentous influences, are not comparable. Some have not seen the alleged antispasmodic effect of atropine demonstrated fluoroscopically.

d. Section of various splanchnic nerves and destruction of coeliacplexus have rarely induced acute superficial ulceration.

e. Sympathetics and vagi.

Experiments upon dogs were performed at Marquette University and at the University of Wisconsin by Carey, Meek, Raine, Stevens and Yates. Both vagi were severed just above the diaphragm. Two weeks later, the dogs' health was apparently unimpaired, no alterations were present in emptying time, depth of peristaltic waves, shape and size of stomach. The coeliacplexus was then removed and again two weeks later, health remained unimpaired and gastric functions unaltered. Control experiments were performed. Coeliacplexus was removed and two weeks later both vagi severed just above the diaphragm. Subsequent observations were identical. Effects upon secretions were not investigated.

A persistence of normal size, shape and contraction of stomach, maintenance of nutrition and stamina indicated that in healthy dogs automatic regulations of gastroduodenal gradient and probably, too, of secretion, was undisturbed. Until it be known how unwholesome impulses are delivered through these nerves, what are their deleterious effects, how their transmission can be blocked and that such interference may not eventually be harmful rather than beneficial, it is safer to avoid meddlesome surgery upon human beings.

ENDOCRINE

Adrenal cortices, incapacitated sufficiently to be effective but not sufficiently to be lethal, provoked gastric ulceration in carnivorous animals. (Marine)

Marine has proved that deficits in the internal secretions of the cortex of the suprarenal glands is present in exophthalmic goitre and in Addison's disease. In both of these maladies, hyperperistalsis and spasm may occur throughout the gastrointestinal tract. In both, symptoms suggesting gastroduodenal ulcers can be prominent; they may so overshadow the other manifestations as to lead to inaccurate diagnosis.

Whether imbalanced endocrinal secretions act directly upon the gastrointestinal tract or indirectly through its extrinsic nerves, is of little moment compared with the fact that such imbalance can be a factor in provoking chronic peptic ulcers in some patients. Apparently there may be atypical forms of both Graves' and Addison's diseases wherein derangement of the automatic regulation of gastrointestinal activities is the chief manifestation and from which recovery is possible if the deficit in the secretion of internal tissue is corrected by administration of cortin.

Clinical Aspects: Introduction

The number of individuals living under similar, or quite identical, conditions that do not suffer from chronic ulcer greatly exceeds the number that acquire the disease. Moreover, there are grades in the susceptibility of the minority. The most susceptible are affected in the first months of life; the least susceptible escape until after they have become senile; those of average susceptibility are afflicted during the interval between senescence and senility.

Frailties of divers types of cells impose the physical and temperamental anomalies that underlie susceptibility. They are inherent; witness the higher incidence of ulcer in races, families and perhaps the sexes. They are also acquired; for example, the influence of age, habits, occupation, as well as the ordinary and extraordinary stresses of living. Climate and seasons have some relationship, not only to the incidence but to the characteristic periodicity of exacerbations of the malady.

Information becomes valuable as it may be efficaciously utilized therapeutically. The one detail most desirable to discover is the anomaly in the susceptible that is the immediate cause of excessive hyperperistalsis and its concomitants, hypersecretion, spasm and intra-gastroduodenal hypertension which occurs in these patients in some phases of their disease. Whatever be the local, regional or systemic factor or factors (dietary indiscretions; recurrent appendicitis or cholecystitis; fatigue, morbid emotionalism, endocrinal imbalance, anemia) proved to have been the pathogenic provocations in a given series of patients, a far larger number of individuals suffering from the same handicaps escape chronic ulceration though they may have comparable digestive distresses. It is unlikely that the gastroduodenal mucosa of people differs so materially in vulnerability as to be of histogenic significance in more than a few exceptions. Consequently, the neuro-muscular organization, either of the entire gastrointestinal tract or of the gastroduodenal segments alone, which regulates all activities of these viscera, differs sufficiently in sensitiveness to stimulation and irritation to be the immediate cause. This state of supersensitiveness varies among susceptible individuals and fluctuates at intervals in the same individual.

This bit of information defines the problems to be solved in the study of each pa-

tient suffering from digestive disturbances suggestive of possible or probable ulcer.

What are the local, regional and systemic influences that provoke excessive responses in stomach or duodenum?

How can they be minimized if they be not eradicable?

Is the instability resulting from supersensitiveness of the neuro-muscular or automatic regulatory apparatus so great that excessive responses (hyperperistalsis, etc.) betokens susceptibility?

How can the supersensitiveness be reduced so as to rehabilitate the automatic regulatory apparatus else the benefits from any or all therapeutic measures must be transient?

It is at once obvious why all patients should receive nonoperative treatment and what measures should or should not be employed for each patient. Moreover, the solutions of the problems provide the indications for the addition of operations to the regime and establish the nature of the procedure best adapted to benefit the individual.

High and uncontrollable supersensitiveness of the regulatory apparatus explains why certain patients suffer from recrudescent and repeated ulceration, hemorrhage and perforation despite all therapeutic endeavors.

Clinical, Pathologic, Roentgenologic, and Nonoperative Aspects

Pre-ulcer stage: Various digestive disorders correlated with hyperperistalsis and spasm, consequent hypersecretion, impaired blood supply and intra-gastroduodenal hypertension usually have occurred repeatedly before the formation of acute ulcers that do not heal promptly and permanently.

Ulcer stage: Similar disorders, notoriously periodic, aggravated by the pain produced by the action of hydrochloric acid and by pressure upon the nerves exposed in the crater of an ulcer, mark the retardation of healing that produces subacute and chronic ulcers. These distresses are commonly accentuated as recrudescent or additional ulceration develops, and frequently before complications occur. Symptomless intervals betoken an absence of irritation and some measure of healing.

History: Great is the value of an accurate history; greater the value of an intelligent interpretation thereof. Symptoms precedent to ulceration in the susceptible can occur and recur with even greater severity in the insusceptible and no demonstrable ulcer result. For example, many suffer from gastric distresses with worry, fatigue, recurrent attacks of subacute appendicitis and cholecystitis, constipation, and from unwholesome ingesta, but few develop more than transient, if any, ulceration. Although the manifestations of subacute and chronic ulcers are similar, the interval between eating and distress, relief obtained from alkalies and milk, the periodicity, etc., the causes of the ulcers may be quite dissimilar, indeed there may be no ulcer present.

ROENTGENOLOGY

Every one suffering from protracted or repeated distresses referable to any portion of the digestive tract should be regarded as likely sooner or later to develop ulcer. An exact diagnosis of the causes of disturbance is obligatory, also an attempt to determine susceptibility or existing insusceptibility.

Serious digestive distresses are associated with disturbances in the gastrointestinal gradient, recognizable fluoroscopically by the presence of hyperperistalsis and spasm, hypoperistalsis and dilatation in one or more segments. Appropriate measures will disclose regional lesions in gall bladder, appendix, or in intestinal segments, causing incomplete active or passive obstruction and repeated examinations will determine whether such lesions are provocative of gastroduodenal hyperperistalsis directly or reflexly. If provocative regional lesions are absent and dietary indiscretions are eliminated, disturbances in the gradient are attributable primarily to mental and nervous instability or to endocrinal imbalance and secondarily to supersensitive neuro-muscu-

lar organization, the automatic regulatory apparatus.

Radioscopy and radiography will usually indicate the presence of an irritated subacute ulcer (incisura) and disclose the size, location and extent of induration of a chronic ulcer. During the course of nonoperative treatment or following operations that have not removed the ulcer, repeated barium-x-ray examinations will determine whether or not gastroduodenal hyperperistalsis and spasm are diminishing and whether or not the ulcer is decreasing in size.

CLINICAL PATHOLOGY*

The incidence of ulcer is increasing and particularly among those subject to morbid emotionalism. In my practice restricted to sanitarium patients, the nervously unstable predominate and among them some form of indigestion is common. Many of them return to the institution, thus providing opportunities for continued observation.

Complaints similar to those of ulcer patients are common, yet the incidence of chronic ulcer is not high under the conditions. According to our observations, the patients harboring ulcer have, or their history indicates that they have had, hyperperistalsis and spasm. However, not all who have or have had gastroduodenal hyperperistalsis develop ulcer, although some subsequently develop the disease after considerable intervals of insusceptibility.

Experiences of one patient are illustrative:

"*First Admission:* Exhaustion and numerous functional nervous symptoms; constipation; with hemorrhoids; indefinite abdominal symptoms. Examination showed tight anal sphincter, with internal hemorrhoids to a moderate degree. X-ray examination showed moderate increase in tone of stomach, spastic distal colon, seventy-two-hour colonic stasis; no organic pathology demonstrated.

"*Second examination* ten months later: Spastic descending and pelvic colon; cecal distention and stasis; incompetent ileocecal valve; hyperperistalsis of stomach.

"*Third examination:* Patient developed acute appendicitis since second visit to the sanitarium, and appendix has been removed. X-ray picture was practically the same as on second examination, with addition of definite cholecystitis.

"*Fourth examination:* Gall bladder had been removed six months before. Symptoms at this time were typical of duodenal ulcer. X-ray examination showed a typical duodenal deformity.

"The sequence of events demonstrated in this patient were first intestinal block at anal ring, with stasis throughout colon; then spastic distal colon, with distended cecum, incompetent ileocecal valve; then subacute appendicitis; and then cholecystitis; on last examination duodenal ulcer."

THERAPY

Prophylaxis: A history of typical periodic digestive disturbances from nervous patients, even with repeated hematemeses, is not positive evidence that an ulcer exists or has existed. Contrarily, a history rather contra-indicative of ulcer may be obtained from a patient having an ulcer of long standing. So, too, laboratory observations can be misleading; anacidity can be present with an ulcer and occult blood be undemonstrable.

Chief reliance is placed in barium-x-ray examinations. Thus alterations in the gastrointestinal gradient are recognized and the likelihood of their producing ulcer can be estimated. These observations and those made from physical examination can be interpreted together with the history. Suitable measures are adopted to aid in the restoration of the gastrointestinal gradient and to help maintain the stability of the automatic regulatory apparatus. Rest, diet, drugs and correcting of unwholesome habits are employed.

Treatment: Whether treatment is to be nonoperative, preoperative or postoperative, certain requirements must be satisfied to provide lasting benefits. Introgastro-duodenal hypertension resulting from bulky ingesta, hyperperistalsis and spasm should be eliminated. Hypertension retards healing, causes pain and reflex spasm and fosters penetration, hemorrhage and perforation.

* The clinical and roentgenologic observations were presented by Dr. F. W. Mackoy, Milwaukee, and from his presentation a summary was made as here recorded.

Hydrochloric acid retards healing, causes pain and reflex spasm which provokes hyperperistalsis. Hunger pains result from forceful peristalsis after the stomach is empty. The acidity of gastric secretions should be reduced by suitable foods supplemented with alkalies and the hunger pains obviated by frequent feeding.

A return of hyperperistalsis after healing has occurred introduces further hypertension and hypersecretion and favors recrudescence at the site of the previous ulcer or the development of an additional ulcer.

The same measures are applicable to the treatment and after care of ulcers as are indicated in prophylaxis and for the same reasons. Changes in occupation and in environment may be propitious, if feasible. However complete the symptomatic relief and how protracted, the patient has been proved susceptible, and unless the automatic regulatory apparatus is rehabilitated and kept stabilized, further ulceration is all but certain to occur when the gradient is again disturbed.

Surgical Aspects

By JOHN YATES, M. D.
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Appropriate operations are indicated whenever the prevention of ulceration or a permanent recovery from ulcer can thereby be promoted the more safely, certainly, expeditiously and economically. Suitable procedures satisfy the four requirements.*

1. Removal or circumvention of local, regional and systemic provocations of gastric and duodenal hyperperistalsis, spasm, hypersecretion and intro-gastroduodenal hypertension.

Nature of provocatives of gastroduodenal hyperperistalsis, etc.

Local. Active obstruction of stomach or duodenum from scar or spasm, perigastritis or periduodenitis and from open ulcer with attendant spasm, the most pernicious form of irritation. Reflux obstruction of stomach from dilatation and stasis in the duodenum.

Regional. Reflex obstruction of stomach or duodenum from recurrent, usually mild, appendicitis and cholecystitis.

Reflux obstruction of duodenum and stomach from incomplete active or passive obstruction in entero-colic segments.

Systemic. Endocrinal imbalance, an actual (exophthalmic goitre) or relative (nontuberculous Addison's disease) hyperthyroxinemia (hypocortinemia).

Central or organic nervous instability acting directly upon regulatory apparatus or producing actual or relative hyperepinephrinemia (hypocortinemia).

2. Stabilization of the automatic neuromuscular regulatory apparatus with restoration of a normal gastrointestinal gradient.

Causes of supersensitiveness of the automatic neuro-muscular mechanism.

Excessive excitation of the mechanism by pressor nerve impulses and hormones until the ganglionic cells producing inhibition are fatigued.

Excessive excitation of mechanism by unwholesome ingesta until the cells producing inhibitory impulses are incapacitated and a similar imbalance, but of an intrinsic type, results.

3. Excision of chronic, recurrent, penetrating and bleeding ulcers and such subacute ulcers as will not heal rapidly and permanently.

Reasons for excision of ulcers. Induration about chronic ulcers, continued irritation and deficient blood supply to subacute ulcers largely the consequence of insufficiently repressed hyperperistalsis and spasm, hyper-

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* The causes of the grades of susceptibility and the bases of insusceptibility to chronic ulcer are tabulated so that the means to reduce susceptibility and to confer insusceptibility may be obvious.

Grades of Susceptibility.	Provocations of Hyperperistalsis, etc.	Musculo-Secretory Units	Supersentitiveness of Neuromuscular apparatus.
1. High	1. Slight	1. Competent	1. High
2. Moderate	2. Moderate	2. Competent	2. Moderate
3. Low	3. Severe	3. Competent	3. Low
Insusceptibility			
1. Wholesome	(Ordinary) (Extraordinary)	Competent	Stable neuromuscular apparatus
2. Unwholesome	(Ordinary) (Extraordinary)	Incompetent	Unstable

secretion and intro-gastroduodenal hypertension.

4. Elimination of any regional or systemic lesions that are responsible for deficient stamina.

Character of lesions reducing stamina. Lesions causing malnutrition, producing toxemia and bacteremia, increasing blood destruction, repeated hemorrhages or interfering with hematopoietic function of bone marrow, gastric mucosa or liver.

Operations. Their types, potentialities and limitations.

INTRINSIC OPERATIONS

Type I. Intrinsic (local) operations (a) gastroenterostomy (b) duodenojejunostomy (c) plastics (d) limited resections (e) subtotal resections (f) atypical resections (g) methods of suturing.

(a) Gastroenterostomy.

(1) Operation of choice, first stage of Billroth II (see below).

(2) Operation of necessity.

Only feasible means to provide immediate relief from obstructions in antrum, pylorus or duodenal bulb or to add a margin of safety after suturing perforations. Gastroenterostomy is effective in promoting symptomatic relief if it restores the gastroduodenal gradient sufficiently to rehabilitate functions. Supplemented with other measures it may foster the healing of subacute ulcers.

Gastroenterostomy does not lead to the complete involution of the fibrous tissue about chronic ulcers or always arrest the subsequent progress of these lesions or even the progress of subacute ulcers, however great or protracted the symptomatic relief it may have afforded. This is attested by the persistence of induration demonstrable with x-ray and by the postoperative incidence of hemorrhage, perforation and in gastric ulcers a development of cancer. The operation may further disturb the gradient and patients are made worse immediately or after an interval when relaxation of the spasm eliminates obstruction. A proportion of the more highly susceptible patients develop more than evanescent jejunal ulcers because their automatic regulatory apparatus is supersensitive and all conditions precedent to serious ulceration are provided. Ulcers likewise develop on the margins of stomas, but are attributable rather to retarded healing after surturing than to high individual susceptibility.

b. Duodenojejunostomy

Incompetence of the musculature in the walls of the duodenum distal to the bulb with consequent passive obstruction (dilatation and stagnation) can provoke hyperperistalsis in the bulb and stomach leading to duodenal or to gastric ulcer. If the entire duodenal musculature is incompetent, gastric hyperperistalsis can institute gastric ulcer.

Whether or not the ulcers be excised, and when feasible they should be excised, restoration of the gastroduodenal gradient necessitates circumvention of the passive obstruction. Gastroenterostomy is less efficacious than duodenojejunostomy. The anastomosis between duodenum and jejunum may be made side to side or after transection of the duodenum and closure of distal end, an implantation of the proximal end into the side of the jejunum. Side to side anastomoses are made distal to the papilla of Vater. End to side anastomoses may be made proximal or distal to the papilla.

Experimental and clinical evidence indicates that end to side anastomoses, perhaps proximal to the papilla may be more certain to restore the gastro-bulbar gradient. Further observations are needed to determine the conditions that warrant one or the other of these procedures, and to establish their limitations.

c. Plastic Operations

These procedures approach the ideal in maintaining the natural channel, in preserving the continuity of the major portion of mucosa, muscularis, nerve and blood supply, thereby interfering relatively little with the automatic regulatory apparatus, thus favoring restitution of a normal gastroduodenal gradient.

Heineke—Mikulicz pyloroplasty.

Finney antro-plasty.

Operations of choice include simultaneous excision of ulcer.

Operations of necessity do not include excision of ulcer.

Application of operations of choice to pyloric, juxtapyloric and antrum ulcers is obvious if the duodenum is mobile or can be mobilized. Utilization of operations of necessity when the ulcer is irremovable so as to promote healing by relieving obstruction resulting from pyloric or antrum spasm (sometimes by suturing bleeding ulcers) which if circumvented by gastroenterostomy might result later, after the spasm subsided, in a more seriously disrupted gastroduodenal gradient with dire consequences only too well known.

Either form of operation is efficacious only if the duodenum is competent and is not rendered incompetent either by the operation or by persistence of causes of disturbances in the distal intestinal gradient. The delivery of gastric contents into a dilated duodenum is one cause of early postoperative fatalities and later of states quite as distressing as those produced by the ulcer.

d. Limited Resections. These operations remove ulcers, but they completely disrupt the continuity of structures. Operative repair is more complicated, and if healing be delayed because of reduced blood and nerve supply and larger incisions, the consequent intramural cicatrices predispose to recurrences of ulcers, to impaired automatic regulation and, consequently, to disturbance in the gastroduodenal gradient.

Billroth I. Operation of choice if plastics are contraindicated. Desirable because it restores the natural channel, and, if healing is good, the gradient may be re-established whether the anastomosis between stomach and duodenum be end-to-end or end-to-side.

It is applicable only if the duodenum is competent and if the viscera can be so mobilized without injury to their blood and nerve supply that they may be approximated without tension after exsection. End-to-end anastomosis is preferable to end-to-side because the duodenum is less apt to be incapacitated by division of its circular muscles.

Billroth II. Operation of necessity. It is applicable if the duodenum is incompetent, if the amount removed precludes restoration of the natural channel or when a two-stage procedure is safer.

It is debatable whether the distal end of the stomach should be closed and a gastrojejunostomy effected, or the end of the stomach, perhaps partly closed, be implanted into the side of the jejunum. The determining factors are how to re-establish an effective gradient and to preserve gastric functions, including a measure of automatic control of emptying. Not only is it desirable to conserve digestive activities but to obviate development of marginal and jejunal ulcers.

The common cause of marginal ulcers is the failure of the sutured margins of the viscera to unite primarily because of faulty approximation, intramural hemorrhage or interference with circulation. Consequently, the scar underlying the margin where physical irritation is certain favors acute ulceration and impedes healing.

Jejunal ulcers, like gastroduodenal ulcers, are not induced by the action of gastric secretions alone. An initiating injury, commonly inflicted by the pressure exerted by forceful contractions of circular muscle upon larger boluses of firm ingesta, ejected before gastric digestion is complete, disrupts the mucosa. Then the continued mechanical irritation, intensified by acid and bacterial contamination, delays repair and imposes chronicity.

The major problem is to provide a stoma that shall imitate a normal pylorus in controlling the rate of ejection of stomach contents and perhaps permit of a reflux. Fluoroscopic studies of patients at intervals after end-to-side (Polya) implantation of stomach into jejunum shows that some of them develop a compensatory sphincter. If the contrast meal contains protein, particularly if the barium be taken during an ordinary meal, the first portion swallowed escapes promptly into the jejunum, but shortly the distal portion of the stomach contracts and opposes egress, more or less natural gastric peristalsis follows, and normal functions are simulated. A similar consequence can be observed after a Billroth II if the stoma is not too large and has been properly placed.

Careful postoperative investigation of series of patients will provide the desirable information. Apparently, smaller stoma are preferable as they divide less of the circular muscle in the walls of the jejunum and impede egress of stomach contents. Stomas in Billroth II operations placed rather close to the end of the stomach seem to be the more effective. The diet of patients after resection should be so designed that the food first ingested is not bulky and an interval be passed before taking of bulky food in order that it will be subjected to more nearly normal gastric digestion before it is expelled from the stomach.

e. Subtotal gastrectomy. These radical operations advocated to reduce acidity and remove ulcer-bearing segments are worse than futile if hyperperistalsis in them can be eliminated.

f. Atypical Resections. Divers combinations of plastic operations and resections needed to remove ulcers higher on the lesser curvature of the stomach and those that have perforated or penetrated, notably into the pancreas, can not be stereotyped. Preservation of as much of the stomach as will regain and retain approximately normal functions is the chief objective.

g. Methods of suturing visceral walls. The simplest safe means that will lead the most certainly to primary healing, should be employed. Primary healing requires accurate hemostasis and approximation of the layers in the walls of viscera. It assures minimal cicatrization and therewith the least liability to marginal ulceration and to impairment of automatic regulation.*

TYPE II. EXTRINSIC REGIONAL OPERATIONS

(a) Teeth—Tonsils—Sinuses. (b) Jejunum. (c) Gall bladder, appendix, diverticulum. (d) Partial active obstructions. (e) Passive obstructions.

(a) Tonsillectomy, extraction of teeth, drainage of sinuses, etc. Infections in these structures, serious enough to impair or to jeopardize health, need correction when there are no digestive distresses. Contrarily everyone suffering from indigestion suggesting a possible relationship to ulcer should not be submitted to avoidable operations because of some hypothetic etiologic significance of the lesions to be corrected. Too much treatment of the unstable individuals susceptible to ulcer is more deleterious than insignificant handicaps.

(b) Jejunostomy. Utilization of jejunostomy in attempts to "cure" ulcer by placing stomach and duodenum at rest is fallacious in that it does not impose immobility nor remove the pathogenic factors. Promotion of healing of ulcers is the better attained by rest, diet, alkalies, etc. Jejunostomy may be added sometimes to more extensive intrinsic operations to foster repair and to provide a temporary means for feeding.

(c) Cholecystectomy, appendectomy, diverticulectomy. Recurrent cholecystitis, appendicitis and diverticulitis may or may not reflexly cause spasm and hyperperistalsis in duodenum and stomach be the patients insusceptible or susceptible to ulcer. Removal of the offending structures is safer if the patients are insusceptible and imperative if they are susceptible. It is to be recalled that recurrent subacute inflammations in the gall bladder, appendix or diverticulum need not have been the serious provocation of hyperperistalsis in those suffering from ulcer and consequently removal of these structures will not always promote healing or prevent recurrent or additional ulceration. Nevertheless, cholecystectomy, appendectomy and diverticulectomy are necessary adjuncts to whatever other measures are employed in treating individuals whose susceptibility to ulcer has been demonstrated.

(d) Operative correction of incomplete enterocolicactive obstruction. Eradication of the gross lesions that cause incomplete active obstruction is indicated whether patients be susceptible or insusceptible to ulcer, and whether or not the recurrent attacks produce gastroduodenal disturbances in addition to the manifestations in the region of the lesion.

(e) Operative correction of passive enterocolic obstructions. The derangements occur in segments of the small and large intestine because of the subcompetence (reme-

* Yates–Raine. Annals of Surgery. Vol. xcii. 1930. p. 410.

diable) and incompetence (irremediable) of their muscularis. The duodenum (already discussed), the distal ileum and proximal colon are the sites most commonly associated with ulcer though the great majority are not so associated.

Passive obstructions occur in unstable and subtonic folk who drive themselves or are driven beyond their endurance. Although their regulatory apparatus is usually supersensitive, the muscles are subcompetent, usually more so than the secretory elements in the mucosa. Consequently, they develop hypoperistalsis, dilatation, hypersecretion and intramural hypotension.

A few of these individuals retain sufficient stamina in their gastroduodenal mucosa to develop reflex hyperperistalsis, etc., and thus acquire ulcer.

It is a nice decision as to whether passive obstructions that remain unresponsive to nonoperative measures should be corrected by operation* and if so, by what procedure. Improved nutrition is demanded for immediate recovery and rehabilitation of the automatic regulatory apparatus for protection against re-ulceration. Operations can contribute to both of these benefits if the patients be not too lacking in stamina and stability.

TYPE III. EXTRINSIC SYSTEMIC OPERATIONS

(a) Lungs. (b) Brain and cord. (c) Vagi. (d) Sympathetics. (e) Vasomotor. (f) Thyroid. (g) Suprarenal glands. (h) Anemia.

(a) Bronchiectasis, pulmonary abscess and tuberculosis. Swallowing of bacteria and other irritants incidental to profuse discharge from trachea impairs nutrition and sometimes contributes directly or indirectly to ulceration. Operative relief is indicated for other reasons and should precede the ulcer phase.

(b) Brain and cord. Certain lesions in these structures do interfere with automatic regulation and may provoke ulceration. It remains to be proved that such lesions can be identified and removed.

(c) Vagus nerve. Resection or temporary blocking of one vagus nerve is futile, of both, unwarranted until proved beneficial and not harmful to human beings.

(d) Sympathetic nerves. It is not known whether these nerves may be severed or blocked beneficially or how this may be accomplished satisfactorily.

(e) Vasomotor nerves. Whether hyperemia can be induced by blocking the vaso constrictors and whether this would confer lasting benefits remains to be determined.

(f) Thyroid. Hyperthyroxinemia provokes hyperperistalsis in the individuals whose regulatory apparatus is supersensitive to this hormone. Excess of thyroxin in the blood is actual in exophthalmic goitre and relative in nontuberculous Addison's disease. Subtotal thyroidectomy in Graves' diseases usually controls the hyperperistalsis; possibly it might be efficacious in Addison's disease.*

(g) Suprarenal. Hyperepinephrinemia actual or relative (hypocortinemia?) instigates hyperperistalsis in people whose regulatory apparatus is supersensitive to this hormone. Crile is removing one and denervating the other gland or denervating both glands in attempts to overcome this anomaly. Benefits have resulted. Judgment must be deferred until further experience establishes the type of patients likely to be helped and the durability of the improvement introduced.

(h) Anemia. Lesions causing toxemia, bacteremia, malnutrition and hemorrhages which lead to increased blood destruction and impair blood formation are to be corrected.

Grave and progressive anemias should be remedied by transfusions of unmodified blood accompanied with the use of paraffined tubes. One transfusion too early or in excess of actual requirements, if properly given, are harmless. One transfusion less than needed to restore the quantity and quality of blood in circulation and to rehabilitate blood forming structure will vitiate recovery.

* Yates–Raine. Annals of Surgery. Vol. xci. 1929. p. 517.

* Administrations of cortin benefits patients suffering from exophthalmic goitre as first demonstrated by Marine, also patients suffering from Addison's disease, demonstrated by Roundtree.

SUMMARY

Chronic gastroduodenal ulcers develop only in those susceptible to the disease. The histogenic factors that produce the conspicuous lesions are deficient blood supply and irritation. The pathogenic influences that accentuate the histogenic factors so that they become effective are hyperperistalsis, spasm, hypersecretion and intra-gastroduodenal hypertension.

The pathogenic factors are provoked by divers local, regional and systemic disturbances but are effective only if the neuromuscular regulatory apparatus, which exercises effective automatic control of all activities in the insusceptible, becomes supersensitive.

The grade of susceptibility of individuals is commensurate with the degree of supersensitiveness of the automatic regulatory apparatus, the severity of provocative disturbances and the competence of the musculosecretory structures.

In order to minimize or to eliminate susceptibility, it is necessary to remove or to circumvent the local, regional and systemic disorders, thus to promote the rehabilitation of the regulatory apparatus so that pressor do not exceed depressor impulses, hyperactivities are eliminated and a normal gastrointestinal gradient is restored.

Suitable therapeutic measures are determined by the degree and causes of individual susceptibilty and may not be routine.

The indications for local, regional and systemic operations are derived from the nature and location of the lesion, its pathogenesis and the status of each patient, not from statistics.

Results of combined nonoperative and operative treatment will vary with the early utilization of measures adapted to meet individual requirements.

Less and moderately susceptible patients will obtain greater and more protracted benefits; the most highly susceptible individuals are unlikely to realize other than temporary relief and are the ones who suffer from recurrent and additional ulceration in spite of treatment.

CONCLUSION

Attempts to "cure" chronic gastroduodenal ulcer by any or all therapeutic measures which do not remove the pathogenic factors peculiar to the disease can not be completely successful.

Claims of internists and surgeons that they have "cured" gastroduodenal ulcer by the employment of such therapeutic measures are unwarranted. Patients may be assisted to recover more or less completely from the disease in which chronic ulcers develop; the ulcers can not be cured.

Attention focused primarily upon the patient, secondarily on the disorder or disorders that have produced the lesion and how to eliminate them, and finally upon the means to promote the healing of acute and subacute ulcers and to remove the recalcitrant and chronic is needed to increase the efficacy of ulcer therapy.

THE JOURNAL CLINIC

Benign Tumor of Small Intestine as a Cause of Severe Intestinal Haemorrhage

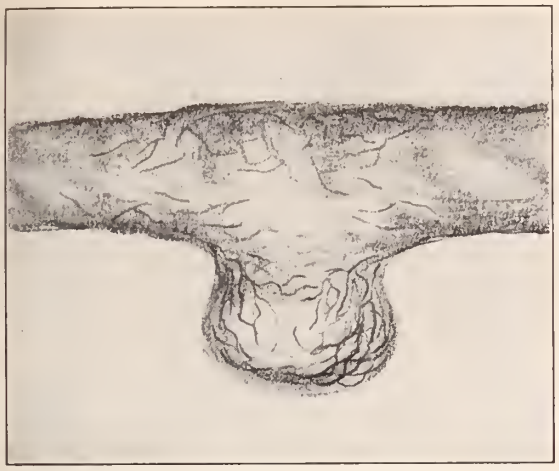
By E. H. MENSING, M. D.
Milwaukee

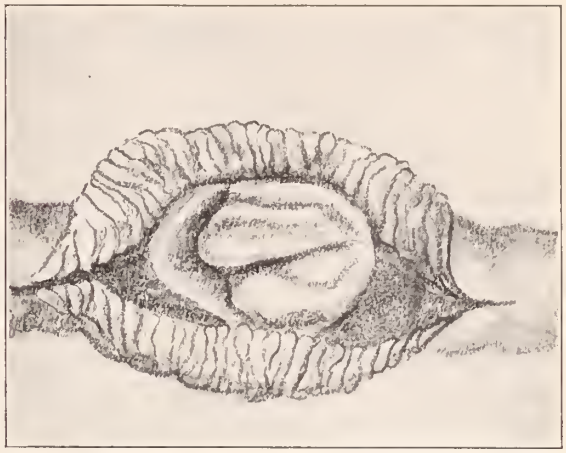
Patient E. E. was admitted to the National Soldiers Home Hospital on 1/8/31 with the history that 3 weeks previously he had had a weak spell and collapsed. He had another spell a week later.

Three weeks ago he noticed that his stools were black in color. They have been black off and on since.

Blood examination on 1/29/31 showed Hb 70% RBC 3,500,000 WBC 9,300.

X-ray examination of chest, stomach and large bowel were negative. Gastric acids





were high. At the end of an hour the free HCL was 64 and total acidity was 120.

Several stool examinations were all positive for blood.

Rectal examination was negative.

General physical examination showed nothing abnormal.

Laparatomy under spinal anaesthesia was performed on Feb. 26, 1931. Exploration of stomach, duodenum, gall bladder, large bowel and appendix revealed no pathology. In the middle part of the jejunum, however, we found a tumor the size of a golf ball. Its surface was quite vascular; it was firm and about the color of the normal intestine.

A resection of the gut with side to side anastomosis was performed and the patient made an uneventful recovery.

On examining the specimen we found that it protruded into the lumen of the gut and that this part of the tumor was ulcerated, accounting for the intestinal bleeding.

Microscopic sections showed a benign leiomyoma of the small intestine.

Traumatic Dislocation of the Knee

By C. KENNETH COOK, M. D.
Section on Industrial Surgery
Jackson Clinic, Madison

Traumatic dislocation of the knee, with little or no injury to the bones forming the joint, is a rather infrequent occurrence. Due to the unusual type of injury and the peculiar associated injuries, I wish to report the following case:

A man, aged forty, was admitted to the accident service of the Jackson Clinic July 7, 1930. He said that he had been injured by an automobile which struck him in the back of the left knee as he stepped from the curb into the street. He complained of severe pain in the left knee and ankle but of no other injuries.

An intern immediately called me and asked me to take care of the case. He said that he had made a hasty but careful examination and the tibia was dislocated forward at the knee with a comminuted fracture of the upper head of the fibula.

Fig. 1. Dislocation of left knee showing dislocation of femur backward and behind tibia.

Roentgenograms were taken at once and revealed the following condition: "Leg and patella displaced forward at the knee and overriding the femur 4 cm. Comminution of the head of the left fibula with displacement. A fragment 1 by 1½ cm. broken off the posterior margin of the astragalus without displacement. A fragment 1 by 2 cm. broken from the supero-postero medial aspect of the left tarsal scaphoid without displacement."

A spinal anesthesia was given with the patient lying on his left side and the anesthesia was limited to this side. Reduction was easily accomplished by gentle flexion of the leg at the thigh and very light traction on the leg. A gutter type splint was applied, extending from the upper thigh to the toes and holding the foot at right angles to the leg.

Examination the following morning revealed a massive hematoma extending from directly above the ankle to the buttock on the left and about one-third the diameter of the extremity. The knee was greatly distended and tense in spite of continuous treatment with icebags since the reduction. Treatment with cold packs was continued for three days at which time the knee joint was aspirated and 100 c. c. of blood was obtained. Following the aspiration the swelling in the knee gradually subsided, although ten days later it was still considerably swollen. The knee was aspirated again and 80 c. c. of bloody synovial fluid withdrawn. It then became approximately normal in size and contour and remained so. Physical therapy was started at the end of the third week with passive motion of the knee and massage of the thigh and leg.

At the end of six weeks the patient was allowed up on crutches with a knee brace and two weeks later he used only a cane. Twelve weeks after the injury he resumed full work, wore the brace constantly, and had no pain. About 90 per cent of the normal function of the knee has returned, although there has been some weakness, it is gradually increasing in strength. At present he can use the leg satisfactorily without the brace, but wears it during work for protection. I believe from the progress this patient has made that there will be less than 10 per cent permanent disability in the knee joint, as all of the fractures have healed without any disability.

This case has been very interesting because none of the several small fractures were displaced and there was no injury to the nerves in the popliteal space, although they must have been considerably stretched at the time of injury. The extensive hematoma was gradually absorbed and the fluid in the knee returned to a normal amount.

I wish to bring out the fact that the admitting intern diagnosed the displacement of the knee and the fracture of the head of the fibula from physical examination alone, and he had only served one week of his internship at that time. This shows that physical diagnosis of fractures can be done by the younger medical men and later confirmed by roentgenograms.

Pellagra-Like Syndrome Occurring in the Course of a Ketogenic Diet Deficient in Protein

By JAMES R. REGAN, M. D.
Milwaukee

The case here reported presents several features that may, not uncommonly, be found in the course of a diet for the treatment of epilepsy by the ketogenic diet. The case represents a growing complication which may occur in the treatment of epilepsy by this procedure. The lowering of protein beyond certain limits may cause the initiation of just such a syndrome as will be reported here. The case report further illustrates the fact that we must not lose sight of other food values when a patient is fed a diet rich in fat content.

CASE REPORT

W. D. an adult male aged 30 years, entered the Soldier's Home Hospital July 9, 1930. At entrance he was suffering with a fracture of the right humerus at the middle third. This was sustained during an epileptic seizure. In April, 1930, he had suffered a fracture at the same site during a seizure.

At that time the radial nerve became engulfed in the callus and an attempt had been made to extricate it at operation, but this procedure proved a failure and the patient had a musculospiral palsy on the right side. He stated that he had been suffering with epilepsy for the past ten years, the attacks becoming more severe and more numerous as time went on. His family history was irrelevant.

His habits were somewhat sedentary. His occupation was a house painter. His past history was essentially negative except for an attack of pneumonia in 1926, which was followed by empyema. This necessitated resection of a rib and drainage.

He stated that he had been having attacks about every day and at times as many as two a day. They were becoming of longer duration, not recovering from the last attack until brought to the hospital, a distance of several miles. He had been taking phenobarbital 1½ grains (0.1gm) twice a day without alleviating the attacks to an extent.

PHYSICAL EXAMINATION

The patient was a well developed and nourished male, aged 30 years and weighing 170 pounds. He showed no nervous manifestations other than that due to the great pain suffered by virtue of the fracture. The scalp showed many scars due to injuries sustained while in the throes of a convulsion. The pupils reacted to light and accommodation. The nasal septum showed a slight deviation to the left, without any obstruction. The tongue was scarred. The neck showed no pulsations, adenopathy or thyroid enlargement. The cardio-vascular system showed no abnormalities. There was a scar in the left chest posteriorly, the result of drainage of the aforementioned empyema. The lungs were normal in every way, except for signs of pleural thickening in the left base. The abdomen was negative. Genitalia were normal. The upper right extremity was greatly swollen with ecchymosis over the middle third. There was a deformity at this point; the lower fragment of the fracture being directed anteriorly at about a ten (10) degree angle with the upper fragment. The fracture was comminuted. Overlying this area was a long linear scar on the outer aspect of the arm. This was the result of the attempt to extricate the radial nerve in April, 1930. The reflexes were normal and no epileptic equivalents could be demonstrated at the time. The urinalysis was negative and the examination of the blood including the Wassermann reaction was negative.

The fracture was treated by means of a Jones' ambulatory traction apparatus and alignment was simple and the healing took place readily.

The patient was placed on a ketogenic diet July 18, 1930, following a period of starvation when ketosis was reached as witnessed by the occurrence of acetone and diacetic acid in the urine. The diet consisted of 77 grams of protein (one gram per kilogram of body weight), 244 grams of fat and 91 grams of carbohydrate. The patient also received 1½ grains of phenobarbital three times a day until September 15 when it was reduced to 1½ grains (0.1 gm) at bed time.

The patient had a moderately severe seizure on July 11 during which he bit his tongue. He had another attack on July 14, moderate in degree.

The fracture united well and the splint was removed on August 10, 1930, and motion instituted.

Due to the absolute wrist drop it was deemed necessary for some plastic work to be done to overcome this deformity. Therefore on November 7, 1930, a tendon transplantation operation was performed according to Jones. The tendons on the flexor aspect being transferred to the dorsal aspect of the forearm. The result was good.

On November 12, 1930, there appeared a swelling of the upper lip and slight edema of the ankles. The urinary findings were negative except for the presence of acetone and diacetic acid. There appeared the following day a dusky desquamating erythema on the dorsum of the wrists, hands and forearms. To a lesser degree this erythema included the face and other exposed parts of the body.

The skin condition increased in intensity the next few days and then seemed to crack in places, especially over the dorsum of the hands. The skin over the entire body was very dry. A blood chemistry determination on November 12 showed the following: N. P. N. 28 mgms., urea 15 mgms., and creatinine 1.2 mgms. per one hundred cubic centimeters of blood. A few days after the onset of the skin condition the patient became morose and melancholy, at times becoming very irritable when he was questioned concerning his skin condition.

Being unable to account for the patient's condition, other than that it appeared to be either an allergic phenomenon or the result of a vitamine deficiency, I placed the patient on cod-liver oil, one drachm three times daily as well as viosterol, plenty of greens, tomato juice, etc. After one week of this type of therapy, there was absolutely no alleviation of the condition. I then questioned the dietitian concerning the diet the patient had been receiving. It was then found that the patient had developed a distinct dislike toward eggs, egg-nog, fish and certain fried meats. These substances had been taken off his diet without, however, substituting anything else in the form of protein to make up for this deficiency. The patient had been receiving 36 grams of protein since November 2, 1930, the time he developed the dislike for the aforementioned foods.

He was immediately placed upon a diet which contained the following: fat 250 grams, protein 82 grams, carbohydrate 100 grams. The patient showed rapid signs of improvement as evidenced by the clearing of the edema in two days and the complete clearing of the skin condition by December 15, 1930.

The urine continued to show acetone and diacetic acid and as the patient was in a state of ketosis, and the skin condition had cleared entirely, and he

had no attacks of epilepsy since July 14, he was discharged from the hospital on February 25, 1931. He was given a diet list and has adhered to it very religiously, as he has been kept under observation since that time and has had no recurrences of the skin condition and has had no attacks of epilepsy.

SUMMARY AND COMMENT

Greer reports a case which is similar to the case reported in which the patient developed a skin eruption and pellagra-like symptoms while on a diet containing 38 grams. The case was treated by means of brewers' yeast (one drachm three times a day) and recovered. Guthrie reports a case of this type occurring in a patient in which the ketogenic diet was poorly balanced, there being a deficiency in the protein intake.

Goldenberger has concluded that the cause of pellagra is due to a deficiency in protein and advocated the use of increasing quantities of foods high in protein content as a measure directed toward its cure and as a prophylactic measure. The work of Barborka has convinced us of the efficacy of a diet high in fat content in the treatment of epilepsy in the adult. In 1922, Peterman directed the attention of the profession toward the treatment of epilepsy by a diet high in fat. Barborka, in figuring the diet, has come to the conclusion that the protein requirement of a patient could be estimated by multiplying the weight of the patient by 1/3. Therefore the patient in the present report would have received approximately 57 grams (170 multiplied by 1/3), had the plan of Barborka been followed.

The type of diet given to patients with epilepsy, to-day, and which seems to be very popular, contains one gram of protein per kilogram of body weight. The case here reported followed this regimen as to protein intake, and as long as this was kept up the patient did very well. McQuarrie holds that this amount of protein is too small, stating that from 1.75 to 2 grams per kilogram of body weight should be administered. However, Barborka reports no untoward symptoms in patients treated by his method and his protein intake is less than that advocated by many. There is a growing interest in the amount of protein that a ketogenic diet should contain. It seems that as the degree of ketosis becomes more marked that there is a growing need of protein in the tissues. In other words, as the diet progresses, more protein should be administered because the deficiency of protein causes an abnormal hydration of the tissues and this feature has a tendency to prevent ketosis or at least to inhibit it to some extent. The opposite is also true, dehydration of the tissues tends to cause or increase the state of ketosis. Therefore arguing from this point it follows that an increase in the protein intake as the diet progresses, favors the maintenance or increases the state of ketosis.

The report of this case illustrates the effect a diet, deficient in one of the food values, can have. This case was treated in a hospital and seemed to be under excellent dietary supervision, and still, in the face of this, developed a deficiency syndrome. The case further illustrates the point of constant scrutiny that must be manifested by those in charge as to the intake of patients on a ketogenic diet. Especially must this factor be borne in mind when the diet must be carried out in the home.

Relapsing Fever: Its Occurrence in a Non-Tropical Area

By M. FERNAN-NUNEZ, M. D.
Milwaukee

This case is reported because of the rarity of the disease in the area in which it appeared (Milwaukee), and to call attention to the possibilities of modern methods of travel (airplane) as a means of disseminating endemic diseases of one territory into another.

J. S., a physician, 36 years old, in apparent excellent health, was suddenly attacked with a severe chill, lasting forty minutes. This was immediately followed by fever rising to 104.2 F. in a few hours. Eight hours after the beginning of the chill a profuse sweat, lasting five hours, was experienced. The fever vacillated around 103 F. throughout the second day, and dropped to 98 F. on the morning of the third day.

Beginning a few hours before and lasting throughout the attack, the patient complained of severe pain in the head, back and extremities. There was nausea during the chill.

The spleen was decidedly enlarged, slight jaundice was observed, and herpes appeared on the lips the second day.

As the patient had left Panama five days previously, arriving in Milwaukee by airplane, the probability of malaria suggested itself. A blood examination on the third day failed to reveal plasmodia. However, quinine sulphate, 30 grains (30 grs.), daily, was prescribed for one week, to be followed by ten grains (10 grs.) daily for two (2) months. The patient returned to his normal activities.

On the twelfth day following the previous attack, a second paroxysm similar to the first occurred, lasting three days.

A second blood examination was made during the febrile stage. No plasmodia were seen, but the slide showed the presence of the spirochaeta recurrentis, Novy type (Borrelia novyi).

An intravenous injection of neoarsphenamine 0.9 gram was administered. Six months later the disease had not recurred, and three blood examinations at different periods proved negative for the organism.

The Dick Test: Summary by Wisconsin State Board of Health

The Dick Test is a clinical test to determine whether a person is susceptible or immune to scarlet fever. It is a solution of the toxin from the scarlet fever streptococcus properly standardized.

TECHNIQUE

The forearms should be washed with soap and water. Following this alcohol may be used. The arm must be absolutely dry before the test is made.

All acids, alkalies and alcohol must be avoided in the sterilization of syringes and needles, since these substances cause precipitation of the toxin. Syringes and needles should be boiled if possible in distilled water. A fresh needle should be used on every patient to avoid possible transmission of infection.

An ordinary hypodermic syringe is not sufficiently accurate. A 1 c. c. Schick or tuberculin test syringe, plainly marked in 0.1 c. c. graduations, and a 26 gauge, 3-8 inch, 1-2 inch or 5-8 inch needle is best suited for this work.

The test is made by injecting intradermally exactly 0.1 c. c. of skin test toxin on the flexor surface of the forearm at the junction of the middle and upper thirds. This toxin contains so little foreign protein that pseudo-reactions are not likely to occur and the control test is not necessary. Each time the needle is changed, care should be taken to expel all water by ejecting 0.1 c. c. of toxin. Failure to do this may cause an error.

Great care is necessary to make the injection intradermal. If the injection is deeper than intradermal no reading can be made. If the needle goes too deep, it must be withdrawn and reinserted at another site. When the test is made correctly a bleb or wheal always stands out in clear relief.

REACTIONS

The reaction should be read in a good light, 22 to 24 hours after the test is made. The faintest reddening, 10 mm. or over in any diameter, means a positive reaction and indicates some degree of susceptibility to scarlet fever. A common error is to call a slightly positive test negative. Positive reactions vary from a faint pink blush to an intense bright red, and from 10 mm. to 60 mm. in diameter. The extent and intensity of the reaction is in direct relation to the degree of susceptibility. A positive test can be made to appear negative by drawing the skin taut. Therefore, tight sleeves must be loosened before the reading. Slight rubbing of the area brings out the color better.

It is good practice to use two tests, one on each arm. The case should be read as positive, if either one shows the characteristic reaction.

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EDITORIALS

AN OPPORTUNITY

We have been informed that contributions for the Beaumont Memorial are lagging, and that most of those received have come only as the result of personal solicitation on the part of a member of the committee. We doctors of Wisconsin should not require personal solicitation to do what we should be glad of an opportunity to do in honor of one of Wisconsin's most illustrious physicians and research students, and to glorify our profession.

Public memorials to the memory of illustrious physicians are altogether too rare. Offhand, we can recall seeing but three or four. Which may account, in part, for the failure of the public at large to recognize the great public service that physicians have contributed.

The Committee's plans are appropriate—an impressive monument, but not an ostentatious one. A cost of between one and two thousand dollars is contemplated. Won't you do your part (whatever you feel it to be) and RIGHT NOW! H. E. D.

PERSONALITY IN MEDICINE

MODERN society tends toward dealing with individual human beings as mere statistical units. Witness most articles on the present depression. This attitude has been reflected in medical literature where disease has been treated largely from the standpoint of abstract entities afflicting given percentages of the population. All of this has its usefulness, but the sick individual is primarily concerned with his personal aches and pains and seeks the physician in hope of being restored to health. Thus the physician, in spite of the trend of the times, is forced to take a personal interest in people and the medical profession has as one of its main duties in modern society the preservation of interest in personality. Emphasis upon this point of view is stressed in the studies of the human constitution which have recently come to the fore, especially in Germany. The more important of these studies are summarized in a great handbook on the "Biologie der Person" edited by Th. Brugsch and F. H. Lewy of Berlin, of which four volumes each containing over 1000 pages have appeared. In this handbook the problem of personality is treated from all sorts of standpoints. It serves to stress, in a learned and at times a ponderous, though usually an entertaining way, the fact known to every good practitioner that medicinal science, as well as the art of medicine, is primarily concerned with human beings as persons rather than as cases. C. R. B.

OUR OPPORTUNITY

THERE is a commodity on the market which, generally speaking, is controlled by the medical profession. There is also a demand that is constantly increasing for this commodity and this demand is very insistent from at least one group, and unless we medical men furnish the goods with ourselves as the marketing organization we shall furnish

the product as salesmen or field men working for the politicians of the State. The writer appreciates that he possibly is not stating facts but only giving his opinion and he also appreciates the fact that he is courting criticism by referring to Health as a commodity and by using the term marketing organization in referring to the medical profession. If the comparisons make the context more clear, I have no apology to make.

"Public Health is Purchasable". We have known that for a long time and proved it to the satisfaction of all thinking folks. Industrial health is also purchasable and it is the demand from industry to which I referred.

The physician who has a practice to sell lists among his assets the connections he has with the industries of his village or city and this asset is the traumatic work which comes from this industry. Employees of industry lose from ten to twenty times as much time from sickness as they do from accidents occurring in industry. In normal economic times and even at the present time, Industry's loss is nearly as great as (and with the productive employee it is greater than) the amount of wages that the employee loses when away from work. It is this loss that makes the demand for the physicians' services.

The reader may ask why the employer does not make his wants known. Some have and they have found some physicians that did not seem to grasp the situation. It takes ingenuity to change the usual. Sickness has always been with us and the physicians have been paid for curative work and not preventive. The physician, in order to meet this demand made for the commodity he should have to sell, i. e., health, must have the ingenuity to translate the value of his services into men working and not men at home sick or in the hospital. That it can be done has been proved time and again. The greatest obstacle to advancement—whether it be the individual or the nation—is the acceptance of the usual as fixed. Doctor Gorgas did not accept malaria and yellow fever as fixed entities in the Canal Zone. They had been present for centuries. They had defeated the French in their attempts to build a canal.

The loss of work of from six to twelve days per employee per year because of sickness is not fixed. It is the usual. Employers do not want it. Employees do not want it. The physician does not want it. That should make it unanimous.

The employer does not speak the medical language. He does not know how to organize a preventive medical service. Many have accepted the usual as fixed and have not even troubled to figure up the loss. It has been a charge against employment maintenance for which few books are kept. The employee has little or no chance of solving the problem. The only one who should know how and has the ability is the physician.

The physician knows that a preventive medical program begins with a careful, preemployment physical examination and this examination repeated as needed and indicated. There must be provision made for the care of illnesses when the employee or employer first begins to feel sick. The rest of the program works itself out in the educational work which the physician does in teaching both employer and employee to use this service. Can the employer afford to pay for this service? Is the commodity which the physician has to sell valuable? Show me something of more value.

If cost accountants are correct in the statement quoted above as to the relative losses of employer and employee, when the employee loses time, then any reduction that can be made in that loss to the employer is a profit out of which the physician may reasonably expect his pay. A saving of six days per employee per year in a plant employing 1,000 men (the ratio would be the same irrespective of number) with an average wage of $5.00 per day would amount to $30,000 for the employer and a like amount for the employees. The employee when "sold health" at the factory, bank, store or other place of employment, carries this message home. He has more money, lives a livable life longer and in proportion spends more on keeping his family well.

Industry is going to buy health. The physician is going to do the work. For whom do you wish to work, yourself or a Commission appointed by the State? C.F.N.S.

THE PRESIDENT'S PAGE

C. A. Harper

THE PHYSICIAN'S MIND BASICALLY SCIENTIFIC

THE first report published by the Wisconsin State Board of Health was in 1878, although the Board was organized in 1876. To a group of medical men in Sauk County representing the Sauk County Medical Society goes the honor of initiating legislation toward the creation of a state board of health. In reviewing the discussions of that time it was found that this group of men were thinking far ahead of the time, believing that ways and means could be devised by which sickness could be prevented and human lives saved. Based on that hypothesis these medical men believed that the state should give official recognition to certain conditions affecting its citizenship so seriously.

It appears that there was very little opposition, if any, raised by the members of the legislature toward the experiment of the creation of a state board of health. There were ten states prior to 1876 that had already organized a state health department. Bacteriology was practically unknown. The germ theory of disease had not been a matter of record. Yet in the minds of these close observers there developed an intuition that some agency, at that time unknown, was a direct factor in causing epidemics of such serious proportions. This but exemplifies the spirit of the medical profession from the day of its incipiency to the present day—always looking ahead for weapons not now possessed to fight the ravages of disease. The meritorious physicians in the early days were certainly pioneering upon unchartered grounds, but possessed that indomitable spirit which the men of the medical profession have always possessed. For an improvement of the human race these men ventured into an undertaking that brought into play the best minds of the medical profession of those days.

We look in one of the early reports and find,"No water-soaked ground can ever be fit for human habitation. Soil moisture is well known to be one of the most prolific causes of tubercular disease." To this may be added the old Indian chief's adage that "the man who plants a tree in front of his house begins to dig his grave." The elimination of sunlight and dryness were found to be essential as a result of observations made. It was not until 1897 that bovine tuberculosis was mentioned in one of the Wisconsin reports, nor was it until 1903 that the term tuberculosis prevailed over consumption and phthisis.

Again, we find "The people must be taught that typhoid is an annual fever introduced into the system by infected water supplies or foul gases from decaying vegetable matter." Apparently the teaching of Pasteur who was then in his heyday had not been inculcated into the rank and file of the profession. The change began, however, in the early eighties and the germ theory of disease began to be promptly recognized.

No epidemics of poliomyelitis were mentioned until 1908.

In the report of 1881 we find an article on "The Growth of Children" by George W. Peckham, M. D., teacher of biology, Milwaukee High School, consisting of 45 pages, which was not only a classic in its day but is a classic of today. Copies of this report have been called for by practically every state in the United States and many foreign countries. Many other articles upon basic principles pertaining to the welfare of our citizenship were written by prominent men in those days, all of which indicates the seriousness with which the medical profession has always carried its responsibility.

This reference shows how great has been the progress in medical science in fifty years as well as incidentally the great progress that has been made in diminishing the prevalence of preventable diseases. Compare this with the fourteenth century where Bubonic plague took twenty-five million lives in Europe; England lost one-half of her people. In London, with its population of 110,000, 50,000 were buried in one cemetery. The disease claimed a toll in Germany of over 1,000,000 lives. Smallpox carried off 50,000,000 persons in Europe during the eighteenth century and was the cause of one-tenth of all the deaths in New York City between 1785 and 1800. History records that during the decade 1751–60, 688 out of every 1,000 children born died before the age of ten. Fifty percent of the English population died before reaching the age of twenty.

Contrast this with the infant mortality rate of 55.7 per 1,000 live births in Wisconsin in 1930. We pride ourselves in the progress of today and well we should, but we cannot but wonder with the great changes that are continually taking place in chemistry and medicine whether a review of the present records will not bring to mind in a future generation of doctors just such another contrast.

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

Officers, 1931

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LIST OF EXECUTIVE OFFICERS OF COUNTY MEDICAL SOCIETIES

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Clark	M. McGonigal, Loyal	E. L. Bradbury, Neillsville.
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Dane	F. J. Hodges, Madison	L. V. Littig, Madison.
Dodge	E. P. Webb, Beaver Dam	A. W. Hammond, Beaver Dam.
Door	John Hirschboeck, Forestville	
Douglas	J. W. McGill, Superior	C. H. Christiansen, Superior.
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Grant	E. A. A. Dunn, Platteville	M. B. Glasier, Bloomington.
Green	W. B. Gnagi, Sr., Monroe	J. F. Mauermann, Monroe.
Green Lake-Waushara-Adams	J. M. Johnson, Ripon	A. J. Wiesender, Berlin.
Iowa	T. A. Hagerup, Dodgeville	H. M. Walker, Dodgeville.
Jefferson	Will Young, Ft. Atkinson	M. G. Peterson, Lake Mills.
Juneau	C. A. Vogel, Elroy	A. T. Gregory, Mauston.
Kenosha	W. H. Bennett, Kenosha	W. H. Lipman, Kenosha.
La Crosse	W. J. Jones, La Crosse	R. L. Eagan, La Crosse.
Lafayette	R. B. Quinn, Darlington	W. B. Williams, Argyle.
Langlade	E. J. Donohue, Antigo	J. C. Wright, Antigo.
Lincoln	F. L. Kelley, Merrill	W. H. Bayer, Merrill.
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Waupaca	R. K. Irvine, Manawa	F. J. Pfeifer, New London
Winnebago	G. V. Lynch, Oshkosh	M. C. Haines, Oshkosh.
Wood	F. X. Pomainville, Wisconsin Rapids	W. G. Sexton. Marshfield.

SOCIETY PROCEEDINGS

BARRON–WASHBURN–SAWYER–BURNETT

A meeting of the Barron-Washburn-Sawyer-Burnett County Medical Society was held at Rice Lake on June second. Following dinner at seven o'clock, Dr. George H. Ewell of the Jackson Clinic, Madison, read a paper on "Prostatic Diseases." Dr. John A. Hurlbut, also of the Jackson Clinic, gave an illustrated talk on "The Injection Treatment of Varicose Veins." E. R. H.

BROWN–KEWAUNEE

Dr. R. G. Leland of the Radio Broadcasting Department of the American Medical Association was the principal speaker at the May meeting of the Brown–Kewaunee County Medical Society held at the Hotel Northland, Green Bay, on Thursday, May 21st.

Dr. Leland gave a very complete and clear explanation of the workings of the Radio Department of the A.M.A., and pointed out the many advantages of radio broadcasting program to be carried out by the local county medical society.

Mr. Hal Lansing, announcer of WHBY, local broadcasting station, was also a guest of the society and expressed willingness of WHBY to cooperate in every way with the local medical society should they decide to go on the air.

Dr. R. L. Cowles reported an unusual case of diaphragmatic hernia in a child three months old. Dr. E. M. Jordan reported an interesting case of angioleucitis with recovery.

At the business meeting, Dr. J. J. Faust, Green Bay, was admitted to membership in the Society. There being no other business the meeting was adjourned. E.S.K.

DANE COUNTY PICNIC

At the invitation of Dr. M. K. Green, superintendent of Wisconsin State Hospital for Insane, Mendota, the annual spring picnic of the Dane County Medical Society was held on the grounds of the State Hospital on June 16th at three-thirty P. M.

A baseball tournament between teams representing the four hospitals in Madison, resulted in the following scores, with Dr. Reginald Jackson as official score keeper:

Madison General defeated Methodist hospital 13 Dr. Fred Davis, umpire.

St. Mary's defeated Wisconsin General 12 to 4; Dr. Fred Daves, umpire.

St. Mary's defeated Madison General 9 to 6 for the championship; Dr. Tom Tormey, umpire.

Methodist Hospital defeated Wisconsin 20 to 5 in the consolation game; Dr. Karl Smith, umpire.

The teams were made up of the following:

St. Mary's—Wirig, Weston, Ellis, Hyslop, Schneiders, Holden Robbins, Purcell, James Dean and Al Tormey.

Wisconsin General—Dimond, Waters, McCann, McGary, Seivers, Greene, Sauthoff, K. L. Puestow and F. Paul.

Methodist Hospital—Cook, Marsh, Shaw, Watson, Hurlbut, Jim Jackson, Bilstad, Rauschwalbe, and J. N. Sisk.

Madison General—Juster, Greeley, Neff, Coluccy, Cummings, Kuehn, E. Sullivan, Aageson, and Kundert.

Sixty members attended the picnic. At seven o'clock a wonderful dinner was served in the Hospital. Following the dinner, a short address was given by Colonel John J. Hannan of the State Board of Control, and the picnic ended with a beginning of sore muscles and a rising vote of thanks to Dr. M. K. Green for his hospitality. L. V. L.

GREEN

The spring meeting of the Green County Medical Society was held on June 18th in the Ludlow Hotel, Monroe. A dinner was served at six-thirty o'clock.

Dr. Arnold Jackson of the Jackson Clinic, Madison, spoke on "Spinal Anesthesia" illustrated with motion pictures.

Dr. J. A. Jackson, also of the Jackson Clinic, talked on "Habitual Dislocation of the Shoulder" which was also illustrated, and Dr. C. Kenneth Cook, Madison, discussed "Treatment of Burns."

GREEN LAKE–WAUSHARA–ADAMS

The Green Lake–Waushara–Adams County Medical Society met in Ripon on May 26th at the Grand View Hotel.

After the dinner, the Woman's Auxiliary of the Society were entertained at the home of Mrs. C. U. Senn, while the members of the Society remained at the hotel to hear Dr. Ralph M. Waters, associate professor of surgery, University of Wisconsin, who spoke on "The Newer Anaesthetic." At the close of the lecture the physicians joined the members of the Auxiliary at the Senn home and a social hour followed.

JEFFERSON

The Jefferson County Dental Society and Jefferson County Medical Society held a joint meeting on Thursday, May 21st, at the clubhouse of the Lake Ripley Golf Club, Cambridge. A golf tournament was held in the afternoon.

After the dinner which was served at six-thirty o'clock, the following program was presented:

"Panel Medicine" by Mr. J. G. Crownhart, Secretary of the State Society.

"Panel Dentistry" by Mr. E. E. Parkinson, Secretary of the State Dental Society.

Dr. Arthur Rogers, Councilor, was present at this meeting and was called upon to lead the discussion.

MARATHON

Dr. W. G. Sexton of the Marshfield Clinic spoke on "Intravenous Pyelography" before a meeting of the Marathon County Medical Society held in the Hotel Wausau on May 19th. Forty members of the Society attended a dinner which preceded the program. Other speakers on the program were Dr. John W. Harris of the University of Wisconsin; Dr. V. E. Eastman, Wausau, secretary of the Marathon County Medical Society, and Dr. J. M. Freeman, Wausau, who presided.

OUTAGAMIE

Mr. B. E. Kuechle, manager of the claim department of the Employers Mutual Liability Insurance Company, addressed a meeting of the Outagamie County Medical Society held in the Hotel Northern, Appleton, on May 12th. A dinner preceded the address.

RACINE

The regular meeting of the Racine County Medical Society was held at Sunny Rest Sanatorium on Thursday, May 21st, at four o'clock.

"Essentials and Value of a Good History in Early Diagnosis of Tuberculosis" was the subject of Dr. T. L. Harrington's address.

Dr. Oscar Lotz, Milwaukee, gave a talk on "Fundamentals of Diagnosis of Early Tuberculosis."

Dr. G. W. Henika, assistant state health officer, Madison, and Dr. Hoyt E. Dearholt, executive secretary of the Wisconsin Anti-Tuberculosis Association, Milwaukee, made timely remarks on the subject of tuberculosis.

A fine dinner was served at six o'clock. S. J.

ROCK

Fifty members of the Rock County Medical Society met in the Hotel Hilton, Beloit, Tuesday, May 26th.

Dr. Francis D. Murphy, professor of internal medicine, Marquette University, gave an address on "Bright's Disease."

Members of the Woman's Auxiliary were entertained at a dinner at the home of Dr. Jessie P. Allen, Beloit. Bridge was played following dinner. At the business meeting, Mrs. T. W. Nuzum, Janesville, vice-president of the Auxiliary, was suggested as delegate to the American Medical Association meeting at Philadelphia. It was reported that the Beloit members had realized $42 from a benefit card party. This money will be used in the Pinehurst project.

SAUK

Dr. Roger Cahoon, Baraboo, was elected president of the Sauk County Medical Society at a meeting of the Society on May 26th at the Midway restaurant at Sauk City. Dr. Edward McGrath, Baraboo, was elected vice-president and Dr. A. C. Edwards, Baraboo, secretary and treasurer.

Three papers were read during the evening's program. Dr. C. W. Henney of Portage read a paper on "The History and Present Status of Blood Transfusion"; Dr. J. Newton Sisk, Madison, spoke on "Analysis of Bone from X-Ray Films"; and Dr. Homer M. Carter, Madison, presented "Pulmonary Tuberculosis in Children."

TREMPEALEAU-JACKSON-BUFFALO

The Trempealeau-Jackson-Buffalo County Medical Society held a meeting in Merrillan the early part of June. It was voted at this meeting to sponsor a clinic for crippled children to be held in Trempealeau county the latter part of June.

Miss Margaret Lison, director of the state work for crippled children, spoke at the meeting and gave an outline of the work being done throughout the state by the Wisconsin Association for Disabled.

Dr. W. D. Stovall, director of the State Laboratory of Hygiene, Madison, spoke on laboratory work.

Dr. R. C. Buerki, superintendent of Wisconsin General Hospital, also gave a talk.

WINNEBAGO

The Winnebago County Medical Society met at the home of Dr. George E. Forkin, Menasha, on Friday evening, June 19th, at eight-thirty o'clock.

Dr. F. Gregory Connell, Oshkosh, gave a clinical report of his trip to the east.

FOURTH COUNCILOR DISTRICT

The sixth annual meeting of the Fourth Councilor District was held Thursday, June 18th, in the Grantland club rooms, Lancaster, Dr. E. A. A. Dunn presiding. The following program was given:

"Some Phases of Socialized Medicine" by Dr. C. A. Harper, president, State Medical Society of Wisconsin.

"Diagnosis and Treatment of Surgical Lesions of the Biliary Tract and Liver" by Dr. Reginald Jackson, illustrated with lantern slides by Dr. J. Newton Sisk, Jackson Clinic, Madison.

"Simple Methods of Managing Diabetic Patients" by Dr. E. L. Sevringhaus, University of Wisconsin Medical School, Madison. Miss Lenore Healy, state dietitian and Miss Marilyn Moore, assisted in the demonstrations.

"Management of Breech Presentations" with motion pictures by Dr. Joseph B. DeLee, presented by Dr. M. Edward Davis, Chicago.

Dinner was served with the Kiwanis Club in the Grantland Club dining room. After dinner, talks were given by Drs. Sevringhaus and Davis, and Miss Healy, and O. F. Christianson led the chorus in singing. M. B. G.

SEVENTH DISTRICT

On May 19th, at Viroqua, the Seventh District of the State Medical Society, held a notably large and interesting meeting. The program was entirely in the hands of Dr. Robert E. Flynn, La Crosse, as President, and Dr. R. H. Ludden of Viroqua, as Secretary, ably assisted by the members of the Ver-

non County Medical Society and the medical and surgical staffs of the four La Crosse hospitals. It was a full day and a very inspiring and informing one.

The committee in charge had provided an excellent program of medical and surgical clinics in each of the La Crosse hospitals. These were held throughout the morning, following which the visiting members and a large delegation of La Crosse physicians drove to Viroqua for the afternoon and evening meetings. Secretary Ludden reports a registration of 150. The attendance, however, was about 185.

Those who presented papers were Doctors W. J. Mayo and R. B. Kirkland of the Mayo Foundation; Francis D. Murphy and F. J. Gaenslen of Milwaukee; Erwin R. Schmidt of Madison and W. H. Condit, professor of obstetrics at the University of Minnesota Medical School.

In selecting the above named essayists, the committee provided for those in attendance a fine array of talent covering a wide field of most interesting subjects. Our district was happy to be honored by the presence of a goodly number of members of other districts. Come again, neighbors.

At the banquet, President Robert Flynn introduced a distinguished Scandinavian physician from Norvaychicago who lightened all our ills by a touching recital of his experiences since leaving the land of ludefisk.

Preceding the addresses of the evening which were given by Dr. W. J. Mayo and Dr. R. B. Kirkland, the Viroqua High School band under the direction of Prof. Otto Brown gave an excellent program. After having observed the manner in which this band of ninety members performed and the manner in which all the details of our meeting had been handled, Doctor Mayo, just before giving his address, made this significant remark, "I shall always remember Viroqua as the biggest little city I was ever in."

Officers for the ensuing year were elected as follows: Dr. A. E. Winter, Tomah, President; Dr. Herbert Townsend, La Crosse, Secretary. The place of meeting will be La Crosse.

Dr. Robert Flynn was given a unanimous vote of confidence for his work as Secretary of the State Board of Medical Examiners, and resolutions, unanimously adopted, were forwarded to Governor La Follette urging Doctor Flynn's reappointment at the expiration of his present term of office.

Through the courtesy of the Mayo Foundation, we had an excellent exhibit of interesting roentgenograms of the stomach, gall bladder and colon. Dr. C. G. Sutherland, also of the Mayo Clinic, was in charge of this exhibit and made it a source of intense interest. Interspersing the addresses and papers were medical motion pictures with sound by Doctors H. B. Kellogg and W. F. Windle and H. O. Jones of the Northwestern University Medical School. Neighbors, meet us in La Crosse next May! S. D. B.

GREEN BAY ACADEMY OF MEDICINE

Dr. Herman Hendrickson, Green Bay, was elected president of the Green Bay Academy of Medicine at its annual meeting in the Hotel Northland, May 23rd. Dr. W. E. Mueller was named vice-president; Dr. P. R. Minahan, secretary-treasurer, and Drs. T. J. Oliver and James C. Colignon, members of the executive committee.

The health and mentality of Mrs. Abraham Lincoln were discussed in an interesting address by Dr. W. A. Evans, newspaper medical writer. It was heard by physicians from Sheboygan, Iron Mountain, Marinette, and Menominee in addition to the Green Bay membership, about eighty-five being present at the meeting.

MILWAUKEE ACADEMY OF MEDICINE

A meeting of the Milwaukee Academy of Medicine was held on Tuesday, May 26th.

Dr. L. M. Warfield, Milwaukee, read a paper on "Congenital Hemolytic Icterus."

Dr. A. R. Barnes, of the Mayo Clinic, Rochester, spoke on "Clinical and Surgical Problems Associated with Coronary Sclerosis."

A joint meeting of the Milwaukee Academy of Medicine and the Milwaukee Pediatric Society was held on June 16th. It was the last of the spring meetings of the Academy of Medicine. The following program was presented:

1. Status Thymicolymphaticus by Dr. Norbert Enzer.
2. More Common Muscular Dystrophies of Childhood by Dr. M. G. Peterman.
3. Endemic Purpuric Bacteriemia in Early Life and Diagnostic Value of Smears from Purpuric Lesions by Dr. Stafford McLean, Columbia University, New York City.

NEWS ITEMS AND PERSONALS

Wisconsin physicians who attended the 28th annual meeting of the American Urological Association at Memphis in May included: Ira R. Sisk, Madison; H. M. Stang, Eau Claire; J. C. Sargent and W. J. Carson, Milwaukee. Papers were presented by Doctors J. C. Sargent, "Suture of the Prostatic Capsule After Prostatectomy and Primary Closure of the Bladder;" and W. J. Carson, "Ascending Infection of the Kidney; an Experimental Study."

Dr. E. A. Pohle, professor of radiology, University of Wisconsin, sailed on May 30th from New York for Germany. He will visit a number of the leading x-ray laboratories on the continent and then proceed to Paris in order to attend the Third International Congress on Radiology. He is to present a paper on the effect of roentgen rays on liver based on research carried out with Dr. C. H. Bunting, professor of pathology, University of Wisconsin. Mrs. Pohle and daughter, Ellen Mae, are accompanying him on the trip.

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Dr. Alfred J. Roach, formerly superintendent and medical director of Pureair Sanatorium, Bayfield, is now engaged in private practice in Ashland with offices in the Knight Hotel Building.

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Doctors T. LeRoy Jacobson and Neal F. Crowe of Delavan, have purchased the Acme building on North Third street and it is now being remodeled into a clinic and emergency hospital.

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Dr. J. W. Prentice was re-elected county physician for the ensuing year by the Ashland County Board of Supervisors.

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Dr. R. C. Lowe, formerly of Richland Center moved the latter part of May to Neenah, where he has opened offices on West Wisconsin Avenue.

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Twenty-two members of Mercy Hospital staff, Janesville, met on June 4th. At this meeting it was voted to discontinue sessions during July and August. Interesting fracture cases were discussed by the physicians following the six-thirty o'clock dinner. A resolution on the death of Dr. G. K. Wooll was read and adopted. Dr. A. H. Pember, President, was in charge of the meeting.

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Dr. James P. Dean, Madison, was elected president of St. Mary's Hospital medical staff for the coming year. He succeeds Dr. F. J. Hodges, who left Madison recently to become professor of roentgenology at the University of Michigan. Dr. L. V. Sprague was elected vice-president of the staff, and Dr. L. Fauerbach, secretary-treasurer.

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Dr. and Mrs. Adolf Gundersen, La Crosse, and son and daughter, Thorolf and Helga, sailed on June 19th from New York on the S. S. Stavangerfjord of the Norwegian line. They will land at Bergen and travel along the coast to Oslo. They plan to spend the entire summer in Norway.

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Dr. Herbert M. Aitken, assistant resident in obstetrics and gynecology, and Dr. Frank Dana Weeks, assistant resident in surgery, both at Wisconsin General Hospital, Madison, are spending the month of July at the home of Dr. Aitken in Bozeman, Montana.

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Eighty crippled children, who have been cared for in the Wisconsin General Hospital and two cottages on Charter Street, Madison, were moved on June 8th to the new state orthopedic hospital for children.

The new hospital is an L-shaped, light brick structure, and is two stories in height, with a third story and tower at the angle. It was erected at a cost of $300,000 and will accommodate 115 patients without crowding. Dedication services will not be held until early next fall.

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Dr. W. W. Bauer of the Racine Board of Health, spoke before a meeting of the Brotherhood of Our Saviour Lutheran Church. Dr. Bauer talked on the work of the health department, and contagious diseases.

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Dr. John Shumate has been appointed to the position of superintendent and medical director of Pureair Sanatorium at Bayfield left vacant by the resignation of Dr. Alfred J. Roach.

Since 1924 Dr. Shumate has been active in tuberculosis work. For three years he was at Nopeming Sanatorium at Duluth, Minnesota, and for the past two and a half years was a member of the staff of Livingston County Sanatorium, at Pontiac, Illinois.

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Thirty eye, ear, nose and throat specialists from the central and northern districts of Wisconsin attended the biennial meeting of the group at Riverview County Club, Appleton, on May 25th. A golf tournament was held in the morning, and in the afternoon Dr. Edwin McGinnis and Dr. Vernon Leach, both of Chicago gave addresses and conducted clinics. After the dinner at the country club, the two specialists again gave talks.

Doctors E. H. Brooks, A. E. Rector, and W. J. Frawley, all of Appleton, were in charge of arrangements for the meeting.

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Dr. Philip R. Fox, Madison, attended the annual American Life convention at Washington, D. C., on May 19th. The organization is composed of directors of various life insurance companies.

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Dr. L. A. Copps, Marshfield, spoke before a meeting of the Kiwanis Club of Wisconsin Rapids in the Rose room of the Hotel Witter. His subject was, "Our Glands and How They Make Us Act the Way They Do."

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Dr. J. R. Minahan of Green Bay in a radio address over station WHBY on June 2nd denounced the "hysteria" that produced the heavy demands on banks in the city the day previous, and pledged every dollar of his wealth to keep open the doors of the three institutions in which he is financially interested.

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Saturday, May 23rd, marked 25 years of practice for Doctors R. G. Arveson and J. A. Diamond of Frederic, most of which have been spent together in the Arveson-Diamond Clinic.

Dr. A. R. Bellerue and Dr. H. F. Beglinger announce the opening of their office in the F. R. A. building, Oshkosh.

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Dr. C. O. Hertzman, Ashland, has opened new offices in the Dodd Clinic, Ashland. He formerly occupied offices in the Masonic building.

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Formal opening of old Fort Howard Hospital constructed in 1816, which was acquired and restored by the city of Green Bay several months ago, was held on June 10th. Speakers at the exercises included Governor Philip F. La Follette, Dr. Joseph Schaffer, superintendent of the Wisconsin State Historical Society, and Mayor Diener of Green Bay.

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Dr. Stuart A. McCormick, Madison, was elected deputy grand knight of the Madison council, Knights of Columbus.

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Twenty-seven attended the sessions of the Wisconsin Homeopathic Society held at the Loraine Hotel, Madison, on June 10th.

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Dr. and Mrs. G. H. Williamson of Neenah returned on July 4th from their European trip with the International Hospital Congress delegates. The meeting of the Congress took place in Vienna, June 14 to 20, where Dr. Williamson took a short course in the International Hospital Clinic. Their travels took them to England, Denmark, Germany, Austria, Switzerland, Czecho-Slovakia, and France.

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Dr. H. H. Morton of Cobb is recovering from injuries received in an automobile accident. To avoid hitting a child, Dr. Morton swung his car to the side of the road, striking a tree. His right leg was fractured.

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Dr. John Mayo Conley, Oshkosh, spoke on "Life After Fifty" before a meeting of the Oshkosh Rotary Club on June 15th.

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Dr. A. L. Millard, formerly of the Marshfield Clinic, joined the Bolton-Mielke Clinic of Appleton in June, succeeding Dr. R. J. Winkler, who has opened offices in Hilbert.

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Wisconsin births in 1930 reached 56,497 to mark an increase of 904 over those of the preceding year, according to the bureau of vital statistics, State Board of Health. Rural births comprised 29,031 of the 1930 total, the survey shows as compared with 27,466 urban births.

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MILWAUKEE

Emmett Echols, son of Dr. and Mrs. C. M. Echols, sailed the end of June for Europe where he will spend the summer.

Dr. and Mrs. J. Gurney Taylor left the latter part of May on an eastern trip. Dr. Taylor, one of the Wisconsin Delegates, attended the 88th Annual Meeting of the American Medical Association in Philadelphia.

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The following interesting announcement was recently made by Dr. Edwin Henes, Jr., executive secretary of the Inter-State Postgraduate Medical Association of North America:

"Dr. Nicholas Murray Butler, President of Columbia University, internationally-known educator and Republican leader, has accepted the invitation of the Association to be the principal speaker at the final session of the Assembly which is to be held in Milwaukee next October. Dr. Butler will also appear as speaker of the evening at the banquet which will be held the same day.

"Dr. Glenn Frank, President of the University of Wisconsin, will be the toastmaster."

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Dr. Francis D. Murphy addressed the Rock County Medical Society at Beloit, on May 26th. His subject was "Bright's Disease."

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Mrs. Frances A. Beebe, mother of Dr. Claude S. Beebe of Milwaukee, died at her home, 2651 Beverly Road, May 30th, at the age of 89 years.

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Dr. and Mrs. H. A. Sifton have closed their town home on Astor Street, and have moved to their country home at Sister Bay, Door County, for the summer.

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Dr. Louis M. Warfield was recently appointed by Dr. J. P. Koehler, City Health Commissioner, to do part-time work in the tuberculosis division of the City Health Department. He succeeds Dr. Charles Ide, who died several weeks ago. Most of Dr. Warfield's work will be at the new Johnston Emergency Hospital.

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Dr. and Mrs. Frank E. Darling and their daughter, Victory, motored to New York to attend the commencement exercises at Columbia University, where their son, Sylvester, received a degree from the College of Physicians and Surgeons.

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Dr. Louis M. Warfield has returned from a ten-day fishing trip.

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Mr. William L. Coffey, superintendent of Milwaukee County Institutions, presented twelve diplomas to the first nurses to be graduated from the new County Hospital, on May 29th.

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Announcement has been made of the appointment of Dr. Eben J. Carey, director of the Department of Anatomy of Marquette University, as director of the medical exhibits at the Chicago World Fair in 1933. Dr. Carey will tour the medical centers of Europe in the interests of the exposition.

The Medical Society of Milwaukee County, following action taken by its Board of Directors, recently directed a letter to the County Board of Supervisors urging the investigation into the present per capita cost of treatment of the indigent sick at the county hospitals. The Society believes that such an investigation may show that many cases are now being hospitalized which could be as effectively treated in the home of the patient at less expense to the County. If the investigation proves this to be true, the Society recommended to the County Board that it study the New York plan whereby a county commissioner of public health handles all calls for medical care of the indigent, authorizing the family physician of the patient or, in the event there is no family doctor, a physician whom he appoints, to provide the necessary medical care. The physician submits his bill to the commissioner who pays it. If hospitalization is necessary the commissioner authorizes it. Except in the case of emergencies, physicians must obtain authorization from the commissioner for every case before he undertakes the work.

Under such a plan it would be possible to set up a panel of physicians available for care of the indigent sick in their homes and hospitalization would be greatly lessened. The Society believes that this plan would prove to be more efficient than the present one, and of less expense to Milwaukee County.

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Dr. John P. Koehler, City Health Commissioner, addressed the Parent-Teacher Association of the William T. Sherman School on June the fourth. His subject was, "My Ideal Parent-Teacher Association."

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The Medical Business Bureau, owned and operated by The Medical Society of Milwaukee County, opened offices in the Mariner Tower Building on June 1st. The Bureau provides the medical profession with a dignified means of aiding the willing debtor to pay his accounts, and of effectively forcing payment from the unwilling debtor. Mr. Gregory Gramling, manager of the Bureau, reports that the response on the part of the medical profession in Milwaukee is very gratifying. Milwaukee physicians have long realized the necessity of following a somewhat uniform system of credits and collections, and the results obtained by the new Medical Business Bureau to date have been equally gratifying to the medical profession.

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Dr. Arthur T. Holbrook attended the commencement exercises at Phillips Exeter Academy, Exeter, New Hampshire, where his son, Matson, was a member of the graduating class.

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Dr. Claude S. Beebe and family have sailed for Europe, where they will spend the summer months.

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Mrs. Edwin Henes, Jr., and Miss Virginia Henes, wife and daughter of Dr. Edwin Henes, Jr., have left for Europe, where they expect to remain for a year.

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Dr. S. N. Franklin, former coroner of Milwaukee, has returned from Europe, where he studied urology and syphilology in the leading clinics of western and eastern Europe. He will limit his practice to urology and syphilology.

BIRTHS

A daughter, Helen Edith, to Dr. and Mrs. Arthur Chandler Taylor, Madison, May 25th.

A son to Dr. and Mrs. T. L. Squier, Milwaukee, on April 28th.

A son to Dr. and Mrs. Edgar Habeck, Milwaukee, on May 15th.

A son to Dr. and Mrs. Norbert J. Wegmann, Milwaukee, on May 29th.

A daughter to Dr. and Mrs. Frank J. Kritter, Milwaukee, on June 8th.

MARRIAGES

Dr. John Barnard Hitz, Milwaukee, to Miss Elizabeth Kroeck, on Saturday, May 23, at Milwaukee.

Dr. Friedrich Eigenberger, Sheboygan, to Miss Violet Hammes, Sheboygan, on Thursday, June 4th, at Sheboygan.

Dr. Jerome W. Fons, Milwaukee, to Miss Genevieve Conerton, daughter of Representative and Mrs. E. P. Conerton of La Salle, Ill.

DEATHS

Dr. A. N. Baer, Milwaukee, died on May 25th at the Sunnyview Rest Farm, Milwaukee.

He was born in Germany in 1865 and was a graduate of the University of Munich, Germany, in 1889. He came to America twenty-five years ago and had practiced in Milwaukee since that time.

Dr. Baer was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

He is survived by his widow and one daughter.

Dr. Thomas R. Bours, Milwaukee, died suddenly June 7th at his summer home at Okauchee Lake. He had previously been in good health.

He was born in Stockton, California, in 1861, and came to Milwaukee when a young man. He was a druggist for a number of years before he became a physician. In 1901, Dr. Bours graduated from Milwaukee Medical College and had practiced in Milwaukee until six years ago when he retired.

He is survived by his widow.

Dr. Harry E. MacLaughlin, Waupaca, died on May 17th at his home in Waupaca.

Dr. MacLaughlin, a veteran of two wars, was born in Crestline, Ohio, January 21, 1872. He was

a graduate of Sioux City College of Medicine in 1904. He served during the Spanish–American war. In 1917 he enlisted as a volunteer surgeon. During the influenza epidemic of 1918, he again entered public health service at Dover, N. J. He came to Waupaca as a practicing physician in 1918.

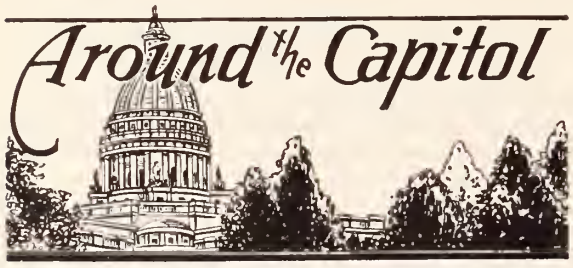
He is survived by his widow and three sons.

Dr. Ralph Atherton Gilfry, Milwaukee, died on June 16th in Columbia Hospital after an illness of eight days.

Dr. Gilfry was born in 1902 and was a graduate of the University of Nebraska Medical School in 1926. He spent two years as interne in Columbia Hospital, after which he was resident physician there for one year. For the past two years he has been in private practice in Milwaukee.

He was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Dr. Gilfry is survived by his widow, his parents, and one brother.



A study of Wisconsin's 521 deaths in 1929 resulting from falls revealed that more than half of the victims were over seventy years old, according to the State Bureau of Vital Statistics. During the same period, people of this age group contributed but 58 victims to the auto accident toll.

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The majority of Wisconsin's eighteen plane crash victims in 1930 were men in their twenties. Five men and one woman in their early twenties, and five men in their late twenties were included in the year's toll, an increase of ten deaths over 1929. Two boys and two girls in their late 'teens and three men in their early thirties completed the list.

* * *

Miss Theresa Gardner, state nurse, has established headquarters at Appleton for the Wisconsin state board of health clinic to be conducted by federal and state representatives on the Oneida Indian reservation. The clinic will be under direction of Dr. C. A. Harper, head of the state board of health.

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The sheriff is required to furnish prisoners only such medical aid as can be provided in the jail, and not outside hospital care, according to an opinion handed down by Deputy Attorney General F. M. Wylie to the District Attorney of Calumet County. When a prisoner goes to a hospital, he must pay his own bill, unless the aid is furnished under the poor relief statutes.

* * *

The Poor Commission has the right in granting temporary relief to take over an automobile of the applicant as security for a repayment of money advanced to him to give him temporary relief, J. E. Messerschmidt, Assistant Attorney General ruled in an opinion to the District Attorney of Douglas County. The county board has the power to stamp an order issued for groceries giving directions to what store to cash such order. The county board may refuse to pay said order if said condition is not complied with and the poor commissioner may refuse to give additional aid to persons who violate such terms until he is reasonably assured that the terms will be lived up to.

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Six years statute of limitation runs against the right to refund from the county in favor of towns, villages and cities for a refund for the support of indigent tubercular patients at the county sanatorium, the Attorney General has advised the district attorney of Winnebago county.

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Gov. Philip F. La Follette has announced the reappointments of Victor P. Richardson, Janesville, as a member of the board of university regents, and of Dr. S. F. Donovan, Tomah, as a member of the board of dental examiners. Both men were originally appointed by Gov. John J. Blaine.

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All counties must adopt the old age pension system by 1933 under a new law now in effect with the signature of Governor Philip F. La Follette.

Under the old age pension system any person over the age of seventy years who lacks means of support can draw a pension up to $1 a day instead of being forced to go to a poorhouse.

A number of counties adopted the system while it was optional and all counties will not be forced to provide the old age assistance outside of institutions. It will still be necessary to have institutions for those old people who cannot be supported outside of an institution but the law is designed to permit many people to escape from poor houses in their declining years.

The first old age pension law was passed in 1925 when it was provided that a county could adopt it by a two-thirds vote of the county board. Then the law was changed so that a majority vote of a county board was sufficient to undertake the new plan and now all counties must adopt it.

* * *

Wisconsin's new orthopedic hospital for children was brought into use when approximately 80 children previously cared for in the Wisconsin General hospital and two cottages on Charter street were transferred to the new building. That the new $300,000 building affords the best equipment known for hospitals of this nature is the belief of Dr. C. R. Bardeen, dean of the Medical School, who sees

in the near future greater accomplishments in giving aid to crippled children not only in correcting their deformities but in building their courage and morale.

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Three hundred ten physicians, including a few from neighboring states, traveled approximately 18,000 miles to and from the University of Wisconsin extension division one-day institutes on the use of insulin in diabetes. The average mileage of the out-of-town registrants was 87.

In announcing these figures, Chester Allen, director of extension field organization, reported that nearly every Wisconsin county was represented at the clinics held in six Wisconsin cities during May. The record distance was covered by a Montreal, Wis., doctor who traveled to Madison, 300 miles, for the half-day course.

» » » CORRESPONDENCE « « «

DAUGHTER'S SALARY DEDUCTIBLE

May 26, 1931.

Dr. — — ———,
———, Wisconsin
Dear Doctor,

You ask if you may deduct on your income tax return the salary of your 19-year-old daughter who is to assist you in your office this summer.

Mr. Usher, Secretary of the Tax Commission, tells us that it is permissible to deduct the amount of your daughter's salary from your income tax return. However, any person 18 years of age or over, whose income is $700 a year or more, is required to file an income tax report.

Cordially and sincerely yours,
J. G. CROWNHART,
Secretary.

HISTORICAL MATERIAL

If you have any material such as letters, diplomas, diaries or old records, pertaining to the history of Wisconsin physicians and medicine, the Secretary will much appreciate a letter reciting the material you have. You will not be requested to present it to the Society,—we are only anxious to know where such source material exists.

J. G. CROWNHART, *Secretary.*
State Medical Society of Wisconsin,
119 E. Washington Ave.,
Madison, Wis.

Scientific Program Nears Completion for 90th Anniversary Meeting of State Medical Society at Madison in September

Three full days of outstanding medical and surgical presentations that will include upwards of twenty out-of-state speakers and sixty presentations by Wisconsin members, constitute the plans of the Committee on Scientific Work for the 90th Anniversary Meeting to be held at Madison on Wednesday, Thursday and Friday, September 9th to 11th, inclusive. The entire Memorial Union Building on the University campus will be devoted to housing this meeting which will bring upwards of 800 members to Madison for its sessions.

That each member may find that of outstanding value to him in his practical work, the program will include afternoon sectional meetings, noon round table discussions, and general sessions that will run from eight in the morning until noon, resume following the early afternoon sections and again for an hour and three quarters each evening. The round table luncheons, that proved so valuable a year ago, will be given two hours and a half this year that each in attendance may have an opportunity to enter into the small group discussion to be conducted by outstanding men in the subjects assigned.

Out-of-state guests that have accepted positions on the scientific programs include Drs. Dean Lewis, Baltimore; Charles W. Mayo, Rochester; J. C. Litzenberg, Minneapolis; H. Earle Conwell, Birmingham, Alabama; Fred W. Rankin, Rochester; Melvin S. Henderson, Rochester; Roy D. McClure, Detroit; W. F. Braasch, Rochester; Joseph C. Bloodgood, Baltimore; Harry B. Culver, Chicago; Herman C. Bumpus, Rochester; Herman O. McPheeters, Minneapolis; George B. Eusterman, Rochester; Gordon B. New, Rochester; Howard L. Beye, Iowa City; Arthur H. Curtis, Chicago; and W. L. Benedict, Rochester.

Wisconsin members on the program and titles of papers follow:

1. Dr. Ralph M. Carter, Green Bay. "Skeletal Traction in Fractures of the Lower Extremities." (Slides)
2. Dr. Arthur E. McMahon, Glenwood City. "Obstetrical Anesthesia and Analgesia in General Practice."
3. Dr. Roy P. Potter, Marshfield. "Roentgenological Findings in Non-Tuberculous Lesions of the Hip." (Lantern Slides)
4. Dr. John M. Dodd, Ashland. "Idealism in the Practice of Medicine."
5. Dr. Henry A. Sincock, Superior. "The Clinical Signs, Symptoms and Treatment of Calcium Deficiency in Pregnancy and its Influence Upon the Child."
6. Dr. Robert C. Thackeray, Racine. "Determination of Circulation Fitness with a Flarimeter."
7. Dr. Carl S. Williamson, Green Bay. "Surgical Indications in Peptic Ulcers."
8. Dr. Reginald H. Jackson, Madison. "Spinal Anesthesia—Résumé of observations based on 3000 inductions. Cinematography film to demonstrate technic and advantages conferred on the patient and surgeon, by this method." (Movie)
9. Dr. Karl H. Doege, Marshfield. "Cardiac Irregularities."
10. Dr. John O. Dieterle, Milwaukee. "Some observations in the Diagnosis and Treatment of the Gas Gangrene Complicating Compound Fractures."
11. Dr. Archie A. Skemp, La Crosse. "The General Practitioner's Response to the Challenge of Obstetrics."
12. Dr. John H. Karsten, Horicon. "The Small Town Physician in General Practice on his Relationship to the Medical Profession."
13. Dr. Hugh P. Greeley, Madison. "Multiple Sensitiveness in Hay Fever and Asthma."
14. Dr. William S. Middleton, Madison.
15. Dr. Frederick A. Davis, Madison. "Experience with Avertin in Eye Cases."
16. Dr. Gunnar Gundersen, (and Dr. R. B. Johnson), La Crosse. "Observations of Duodenal Obstruction."
17. Dr. Chas. M. Gleason, Manitowoc. "Relation of the Life Insurance Examiner, to the Agent, the Company, and the Applicant."
18. Dr. Joe N. Sisk, Madison, and
19. Dr. Lawrence V. Littig, Madison. "Cholecystography." (Movie. Joint paper with movie.)
20. Dr. Mark Nesbit, Madison. "The Eye and General Medicine."
21. Dr. Henry B. Hitz, Milwaukee. "Acute Mastoiditis."
22. Dr. Ernest W. Miller, Milwaukee. "Electric Burns."
23. Dr. Ralph M. Waters, Madison. "Clinical Aspects of Anorexia."
24. Dr. Francis E. Butler, Menomonie. "Two Years Experience with Spinal Anesthesia."
25. Dr. Clarence N. Hatleberg, Chippewa Falls. "Diagnosis and Treatment of Ectopic Pregnancy."
26. Dr. Robert E. Burns, Madison. "Osteomyelitis."
27. Dr. John C. Doolittle, Lancaster. "Some Lessons Learned from Our Mistakes."
28. Dr. Arthur V. De Neveu, Milwaukee. "Skull Fractures and Treatment; a Review of 600 Cases."
29. Dr. Hartwig M. Stang, Eau Claire. "Intravenous Urography; Its Place in Urology and General Practice."
30. Dr. Joseph Dean, Madison. "Appendicitis."
31. Dr. Raymond N. Nelson, Horicon. "The Ammoniacal Diaper."
32. Dr. Nels Werner, (and Dr. Garner Scullard), Eau Claire. "Evaluation of the Schilling Blood Count in Diagnosis."
33. Dr. Karl W. Doege, Marshfield. "Cancer—Constitution and Predisposition."
34. Dr. James K. Trumbo, Wausau. "Ocular Manifestations of Focal Infections."
35. Dr. Andrew J. Weber, Milwaukee. "Arthritis of the Spine with Reference to Industrial Accidents.
36. Dr. Leslie W. Tasche, Sheboygan. "Carcinoma of the Oesophagus."
37. Dr. Mynie G. Peterman, Milwaukee. "The Treatment of Epilepsy in Children."
38. Dr. Robert L. MacCornack, Whitehall. "Embolism and Thrombosis of the Mesenteric Vessels."
39. Dr. Everett L. Mason, Eau Claire. "Purpura Hemorrhagica."
40. Dr. Albert A. Axley, Washburn. "The Small Community Hospital."
41. Dr. Guy R. Duer, Marinette. "Practical Problems in the Practice of Medicine."
42. Dr. Edward S. Ryan, Sheboygan. "Conservative Treatment of Nasal Infections."
43. Dr. Herman T. Schlegel, Wausau. "Treatment of Asthma."
44. Dr. Edward H. Spiegelberg, Boscobel. "Congenital Pyloric Stenosis."
45. Dr. Justin D. Leahy, Park Falls. "Injuries of the Back."
46. Dr. W. G. Riopelle, Beaver Dam. "Medical Economics."
47. Dr. Otto V. Pawlisch, Reedsburg. "Problems of Arteriosclerosis in General Practice."
48. Dr. Roger C. Cantwell, Shawano. "Substernal Pain."
49. Dr. J. F. Mauermann, Monroe. "Catarrhal Enteritis Simulating Pelvic Disease in Women."
50. Dr. Volney B. Hyslop, Madison. "Principles to be Observed in the Treatment of Congenital Harelip and Cleft Palate."
51. Dr. Harold M. Coon, Stevens Point. "Positive Factors in the Diagnosis of Pulmonary Tuberculosis."

Memorial Union Building on University campus which will house September annual meeting.

52. Dr. Geo. V. Lynch, Oshkosh. "Pathological Conditions of the Genitourinary Tract that Require Transplanting the Ureters into the Sigmoid."
53. Dr. August Sauthoff, Mendota. "Alcoholic Psychoses."
54. Dr. Edwin F. Schneiders, Madison. "The Early Recognition, and Adequate Treatment of the Precancerous Lesions of the Cervix."
55. Dr. James B. Vedder, Marshfield. "External Cephalic Version." (Motion Picture.)
56. Dr. Harold R. Fehland, Wausau. "The Anemias of Adolescence." (Lantern)
57. Dr. Jennings C. Litzenberg, Minneapolis. "The Delivery of Occiput Posterior."
58. Dr. H. Earle Conwell, Birmingham, Alabama. "Fractures of the Spinal Vertebrae Without Cord Injury." (Lantern slides)
59. Dr. Roy D. McClure, Detroit. "The Result of the Use of Iodine Salt in Detroit as Noted in the Effect Upon the Demand for Surgery is Concerned."
60. Dr. Harry B. Culver, 7 West Madison St., Chicago, Ill. "Significance of Renal Pain."
61. Dr. Wm. F. Braasch, Rochester. "Urology and the General Practitioner."
62. Dr. Herman C. Bumpus, Rochester. "Punch Prostatectomy."
63. Dr. Chas. W. Mayo, Rochester. "Pharyngo-esophageal Diverticulum."
64. Dr. Melvin S. Henderson, Rochester. "Fractures of the Lower Extremities."
65. Dr. George B. Eusterman, Rochester. "Observations on Carcinomatous Gastric Lesions Masquerading as Benign Ulcer." (Slides)
66. Dr. Fred W. Rankin, Rochester. "Encouragements in the Surgical Treatment of Cancer of the Colon and Rectum."
67. Dr. W. L. Benedict, Rochester. "Infection of the Pelvic Organs of the Female in Relationship to Diseases of the Eye."
68. Dr. Gordon B. New, Rochester. "The Developments in the Treatment of Deformities of the Face and Neck." (Lantern)
69. Arthur H. Curtis, 104 S. Michigan Ave., Chicago, Ill. "Stricture of the Uterine Cervix, its Etiology, Clinical Characteristics, and Complications;—Treatment."

70. Dr. Herman O. McPheeters, 900 Nicollet Ave., Minneapolis. "The Mechanics of the Reverse Flow of Blood in Varicose Veins and its Clinical Application to the Injection Treatment." (Slides)
71. Dr. Howard L. Beye, Iowa City, Ia. "Transphrenic Infections." (Slides)
72. Dr. C. A. Harper, Madison. President's Address.
73. Dr. Otho Fiedler, Sheboygan. President-Elect's Address.
74. Dr. Joseph F. Smith, Wausau. "Report of the A. M. A. House of Delegates."
75. Dr. J. Gurney Taylor, Milwaukee. "Report on the Scientific Exhibits at the A. M. A. Meeting."
76. Dr. W. E. Bannen, La Crosse. "Report on Sections and Section Work of the A. M. A. Meeting."
77. Dr. Joseph C. Bloodgood, Baltimore. "The Control of Cancer Through Education."
78. Dr. Dean Lewis, Baltimore.
79. Dr. John W. Powers, Milwaukee. "Evaluation of the Various Treatments for Ununited Fractures of the Hip."
80. Dr. Eugene S. Sullivan, Madison. "The Surgical Problem of Pelvic Endometriosis."
81. Dr. Samuel J. Fogelson, Chicago. "The Present Status of the Mucin Treatment in Peptic Ulcer."
82. Dr. John L. Garvey, Milwaukee. "Spontaneous Subarachnoid Hemorrhage and The Clinical Significance of Blood in the Spinal Fluid."

Wisconsin Physicians Contribute to Erect Memorial to Dr. William Beaumont at Site of Second Fort Crawford

A memorial to the work of Dr. William Beaumont who completed his first experimental work in physiology at Prairie du Chien just one hundred years ago, will be erected some time this summer as result of donations from Wisconsin physicians. Approximately a third of the sum necessary was received during June as result of a special letter to physicians by the Committee in charge of the Memorial. Dr. Curtis A. Evans, Milwaukee, is chairman of this Committee whose other members are Dr. F. J. Antoine, Prairie du Chien; Dr. William Snow Miller, Madison, and Dr. P. L. Scanlan, Prairie du Chien.

It is understood that the memorial to be erected on S. T. H. 18 will result in the name of the street being changed to "Beaumont Road." The memorial is to be a bronze placque on a large Wisconsin granite boulder.

Those whose contributions to the Memorial have already been received at offices of the State Medical Society, Madison, are:

Luella E. Axtell, Marinette
F. H. Baldwin, Bloomington
W. E. Bannen, La Crosse
C. R. Bardeen, Madison
Julius Blom, Woodville
R. W. Blumenthal, Milwaukee
A. W. Boslough, Wausau
T. G. Brehm, Racine
F. E. Butler, Menomonie
F. Gregory Connell, Oshkosh
H. M. Coon, Stevens Point
R. S. Cron, Milwaukee
Carl Henry Davis, Milwaukee
F. A. Davis, Madison
Hoyt E. Dearholt, Milwaukee
G. M. Dill, Prescott
Carl W. Eberbach, Milwaukee
W. J. Egan, Milwaukee
J. J. Eisenberg, Milwaukee
C. A. Evans, Milwaukee
Edward Evans, La Crosse
James A. Evans, La Crosse
G. H. Ewell, Madison
E. A. Fletcher, Milwaukee
F. D. Fleury, Omro
O. H. Foerster, Milwaukee
F. P. Foley, Dorchester
G. E. Forkin, Menasha
H. V. Foshion, Algoma
Philip R. Fox, Madison
W. E. L. Froggatt, Cross Plains
J. F. Fulton, Yale School of Medicine, New Haven, Conn.
F. J. Gaenslen, Milwaukee
Wm. J. Ganser, Madison
John S. Gordon, Milwaukee
J. J. Gramling, Milwaukee
Gunnar Gundersen, La Crosse
Louis R. Head, Madison
A. F. Heising, Menomonie
W. A. Henke, La Crosse
J. V. Herzog, Elkhorn
G. A. Hipke, Milwaukee
H. B. Hitz, Milwaukee
John Hogan, Maiden Rock
A. T. Holbrook, Milwaukee
Reginald H. Jackson, Madison
G. L. Karnopp, Wautoma
M. J. Koch, Milwaukee
W. L. LeCron, Milwaukee
G. W. Leitch, Milwaukee
H. D. Ludden, Mineral Point
R. H. Ludden, Viroqua
D. W. Lynch, Milwaukee
M. A. McGarty, La Crosse
Alex Montgomery, Milwaukee
R. C. Mundt, Oconomowoc
J. W. Prentice, Ashland
H. Rasmussen, Milwaukee
T. J. Redelings, Marinette

A. W. Rogers, Oconomowoc
R. G. Sayle, Milwaukee
B. H. Schlomovitz, Milwaukee
A. F. Schmeling, Columbus
Gustav Schmitt, Milwaukee
Philip Schmitt, Milwaukee
P. A. Schulberg, Durand
C. U. Senn, Ripon
H. A. Sifton, Milwaukee
Rock Sleyster, Wauwatosa
Joseph F. Smith, Wausau
Ralph Sproule, Milwaukee
G. M. Steele, Oshkosh
T. L. Tolan, Milwaukee
R. M. Waters, Madison
J. F. Wilkinson, Oconomowoc
W. M. Wochos, Kewaunee
J. C. Wright, Antigo

The High Cost of Medical Service*

By LOUIS F. JERMAIN, M. D.
Dean Emeritus
Marquette University School of Medicine
Milwaukee

During the last three or four years we have quite frequently read discussions in the public press, in magazines and in medical journals on "The High Cost of Medical Service".

Just what is meant by "The High Cost of Medical Service", is not always clear from these discussions. In discussing this subject the phrase "the high cost of sickness", should be substituted because at least three major factors enter into the problem: First, medical and surgical service; second, hospital care and service, and third, nursing service.

Generally, however, because of the use of the phrase "the high cost of medical service", it is becoming evident that the impression, and perhaps the conviction, has spread that the organized medical profession is responsible for, and is the recipient of this increased cost.

It is quite apparent that this propaganda is already beginning to create in the minds of the public the feeling that the medical profession is a band of profiteers exploiting and capitalizing human misery and sickness.

Wealthy and powerful organizations have already undertaken the establishment of clinics with the express purpose of reducing the cost of sickness, thereby, further spreading the conviction that the medical profession is responsible for this increased cost.

MEDICAL AND SURGICAL SERVICE

I have stated before that there are at least three major factors that enter into this discussion. Let us first consider the part the medical profession is playing in the cost of sickness. Careful investigation into the conditions here in our own county and State reveals the fact that although the cost of sickness has greatly increased in the last 35 years, it has not increased nearly as much as the cost of living in general and that the medical profession is the recipient of only a very small proportion of this increased cost.

Thirty-five years ago the average fee paid the doctor who visited the patient in his home was one and a half dollars. To-day careful inquiry reveals that the average fee for this same service is two and one-half dollars, an increase of less than 100%. During this same period the doctor's living expenses have increased 300% to 400%. He is obliged to travel over a much greater territory and cannot give prompt and adequate service without purchasing a new automobile at least every three years and maintaining the same.

Physicians in this city often actually make home visits to patients, give them the benefit of their knowledge and experience for less money than the taxi-fare would be to cover the same distance.

Thirty-five years ago the average fee for a major surgical operation was about $75.00. Careful inquiry among about a dozen of my surgical friends in Milwaukee reveals the astonishing fact that to-day the average fee for this work is $100.00, not much more than it was four decades ago. At that time men like Drs. Senn, Mackie, Ladd, Levings and Sifton did surgical work for me and I well remember what their fees were. Obstetrical fees at that time averaged about $15.00. To-day I am quite certain that the average

* Presented before Medical Society of Milwaukee County, May, 1931.

obstetrical fee in this county is not over $35.00.

Three decades ago the doctor needed for his office only two rooms, one a waiting room containing a rug, a table and some chairs; the other an examining room containing a desk and an examining table or chair. All the scientific instruments he needed were a microscope, a stethoscope, an ophthalmoscope, obstetrical forceps and a few other very inexpensive instruments of precision. Many times he possessed only a pocket surgical case for the surgical work he was obliged to do.

To-day the conscientious, scientific physician who desires to do high grade scientific work and give his patients what they demand, namely, everything that modern medical science has to offer, must prepare to invest in office equipment a sum varying from ten to fifteen thousand dollars. The equipment, however, is not all that is required. In order to make proper use of this equipment, he must rent at least two or three additional rooms, he must employ a laboratory technician, perhaps an x-ray technician, and he must maintain rapidly depreciating equipment.

To-day every physician who desires to give adequate and scientific service needs an x-ray machine. He needs a well equipped laboratory to do the usual routine clinical, chemical, pathologic and bacteriologic tests. He needs a metabolic rate machine. He should have an electrocardiograph and many other expensive scientific instruments of precision, too numerous to mention.

Not only does the honest and up to date physician feel that in order to do his best he must have these things, but the public demands them. It not infrequently happens that a patient comes to the office and demands an x-ray examination of his stomach because of a fear of cancer; another will demand a metabolic rate test because he fears a toxic goiter, and still another wants an electrocardiogram because he has cardiac palpitation. The physician may have an honest conviction that the patient does not need these expensive examinations, but his argument does not convince and the patient repairs to some other office or laboratory where he can get what he wants.

If we compare the cost of medical education to-day with that of the early '90s, we find at that time one could secure a degree from the best medical schools in the country at the end of three years at an expense of from $1,200 to $1,800. Today it takes seven years or more of study after graduation from high school, and the actual cost in money ranges from six to ten thousand dollars.

There is no eight hour day for the physician. There are no free Saturday afternoons or Sundays, most of them must be ready to work all hours of the day and night, and very few can expect additional pay for night work or overtime.

I have had the privilege during my medical career of as close a contact with the rank and file of the medical profession of this State as any man, and it is my impression that the average gross income of its members is less than $5,000 per year. Most of them pay their bills, support their families, educate their children and lead respectable lives, an almost impossible task at the present time under present conditions.

An investigation made by Harvard, among its own graduates in medicine, revealed the fact that it takes the average graduate 12 years to reach an annual gross income of $5,000 and that for his first two years of practice the average is only slightly over $1,000.

In discussing this question with a prominent manufacturer of this city, he gave me the following example: He and another young man were room-mates and chums at Harvard; he took up engineering, while his chum studied medicine. He admitted that his chum was intellectually in every respect his superior, yet 15 years after graduation he was president of a large manufacturing concern, perhaps a millionaire, while his chum who graduated with high honors was still struggling for an existence.

A physician making house calls with his horse and buggy 35 years ago could lay aside a penny for a rainy day. Today such a thing to the large majority is an impossibility.

For 37 years I have visited the County Hospital of Milwaukee County twice weekly for the purpose of caring for the indigent

sick and many other physicians and surgeons are giving the same service without one cent of compensation. At the same time, if an indigent criminal is brought before the Court, the judge appoints an attorney to defend him and the County pays the attorney.

If a prominent and skillful surgeon attempts to collect a fee of ten or fifteen thousand dollars from a multi-millionaire for a life-saving operation, there are first page headlines in the newspapers; when an attorney collects twice that sum for services rendered, nothing is said about it. The former is a very unusual incident, while the latter is a common one, yet the former deals with life and health while the latter perhaps deals with property only. If a real estate agent or a trust company transfers, let us say a $30,000 mortgage or loan for you they charge you $600 for this simple transaction, a fee seldom received by a physician or even a surgeon.

The medical profession has for years and is still devoting much of its time and thought to the scientific investigation of disease, its prevention and alleviation. Thousands are working in research laboratories for a salary that would be scorned by a bricklayer or a plumber.

The medical profession has always been the first on the field of distress,—no other group of individuals does so much for charity. They are constantly engaged in formulating and promulgating the laws of health for the guidance of the public. Why in the name of decency and fairness should they not be entitled to a respectable and comfortable existence?

We freely admit that it is quite a shock to a family in moderate circumstances to receive a bill for two or three hundred dollars for medical, hospital and nursing service, especially if Dad has just recently purchased a $1,500 automobile on the partial payment plan and Milady has bought a four or five hundred dollar fur coat on the installment plan. What philosophy of life is it that prompts a man to pay four to five hundred dollars for a fur coat for his wife with a smile; while he growls and groans and refuses to pay an equal sum for the saving of the life of a dear one.

Let us in every way by word and pen combat the nasty and untruthful insinuations that the medical profession, the hospitals and the nurses are capitalizing sickness. Let the medical profession and medical societies resist with all their might the attempt to debase them and drag down to the level of commerce the high and noble ethics and traditions of the medical profession.

I do not believe we should be obliged to accept advice and control by any group of lay individuals who, without any knowledge of real conditions and not familiar with the problems and ethics of the profession, volunteer to conduct our affairs. Dr. Gilbert E. Seaman recently made a very appropriate query. "Why should the medical profession permit a management of its affairs by any group of individuals who cannot manage their own in a manner to prevent periodic crashes in the market, general business depression and unemployment costing our nation billions of dollars?"

THE HOSPITAL

Now let us consider the second factor in the cost of sickness "the Hospital". We are now living in what may be termed the hospital era. Today the patient seeks the hospital when he is ill, not only for surgical operations, but for internal disorders requiring only medical care. Three decades ago it was extremely difficult to persuade a patient to enter a hospital except for surgery. At that time a very large percentage of women were delivered in their homes and medical cases were practically all treated in their homes. Today it is the sanitarium and the hospital they seek. To-day it is very seldom that a woman is delivered in her home. The reason for this change is primarily the attitude of the patient towards the hospital. He no longer fears the hospital, but realizes that when sick his comfort and recovery are best promoted in this institution.

A very large percentage of the middle class, those with which we are principally concerned in this discussion, no longer live in their own homes but in small apartments where proper care and nursing can not be given them and must seek hospital care. It is true that a great deal of money is expended in the hospitalization of patients, but that

is mainly because so many more patients demand hospital care.

Let us try and determine if hospital rates are too high. During the period from 1895 to 1905 the average rate for hospital beds was about $15.00 per week, this included food, laundry and general nursing. To-day the average cost per bed is about $40.00 per week, no more of an increase than we find in hotels, boarding houses and rents in general.

Hospitals in those days were merely places where patients lived when they were obliged to undergo a surgical operation. There were no laboratories of pathology, chemistry, bacteriology or x-ray while today all this equipment is a necessity. Besides, these laboratories must be manned by experts in the various branches of science and technicians are needed to do the routine technical work.

In 1896 I was appointed a member of a Committee whose object was to investigate the cost of hospital construction. After a prolonged investigation this committee concluded that the cost of construction and equipment of a modern hospital, including the ground, was about $1,000 per bed capacity. Last year our St. Joseph's Hospital was completed at a cost of $5,000 per bed capacity on moderate priced ground in the northwestern outskirts of the city. In other words, at the present prices of building and equipment a 350-bed hospital will cost over $2,000,000.

I have learned from reliable hospital authorities and superintendents that in the hospitals of Milwaukee the cost per patient per day 30 years ago was slightly over $1.00; to-day the cost per patient per day is $5.00 in the average. Another important fact must be taken into consideration in this connection,—at that time the average stay of a patient in the hospital for any condition at all serious was about four weeks, while today it is less than two weeks.

A survey given to me by the Rev. H. L. Fritschel of the first 100 patients admitted to the Milwaukee Hospital in 1930 shows that the average stay in the ward beds of the hospital was 9.5 days; the average stay of maternity cases was 12.5 days, and the average stay in private rooms was 12¾ days. The average cost to the patient of a ward bed was $4.54 per day, the average cost to maternity cases was $6.72 and in private rooms $7.21. This included all expenses paid the hospital for room, food, nursing, operating room service, laboratory examinations, x-ray examinations and ambulance service; and in maternity cases included care of the baby.

Who is responsible for this marked decrease in the time of individual hospitalization and the consequent economic gain? The medical profession, through correct diagnosis, improved technic and asepsis; the hospital, because of perfect sterilization of instruments, dressings and suture material, and the nurse, because of more intelligent and scientific nursing.

Forty dollars per week for a hospital bed seems a great deal of money, but when we take into consideration the short stay of the average patient in the hospital and when we remember the fact that the actual cost per patient per week to the hospital is about $35.00, we surely cannot honestly say that the hospital rates are excessive. Go to any first class hotel and you will pay $35.00 a week for your room alone, without food, laundry, nursing or any of the numerous services given you in a hospital for approximately the same price. It is well known among physicians, hospital boards and superintendents that no hospital, not conducted by charitable Sisterhoods, can expect to keep out of the "red" for any length of time at present prices and demands. Practically all of them face an annual deficit and must go begging to cover it.

THE NURSE

Now let us consider the third major factor in the cost of sickness "the Nurse". It is true that three decades ago the average fee for nursing was about $15.00 per week, and that at present the average is about $50.00 per week. However, let us compare this increase in the cost of nursing with the increase in other workers and commodities. Forty-five years ago I worked in this city as a carpenter for 12½ cents per hour. Today, the carpenter doing the same work earns from $1.00 to $1.25 per hour, an increase of almost 1,000%. The same is true of the plumber, the bricklayer, the plasterer and painter. At about that same time I taught school in the public schools of Wisconsin for

$35.00 per month, paid $10.00 a month for room and board and saved some money. A pound of butter was 10 to 15 cents and a dozen eggs 8 to 12 cents. A good pair of shoes could be purchased for $3.00 and a good suit of clothes for $15 to $20. The best movie picture show 30 years ago could be seen for 5 cents, and I paid six cents a gallon for gasoline to drive my first car.

In the face of the above mentioned facts, is the nurse overpaid? She must lead a respectable life, must dress well and maintain an apartment whether she is on or off duty. I think the facts stated will convince you that, although there has been complaint about the high cost of nursing, her fee has not increased at nearly the same rate as have the wages of the laborer and the artisan, and that the increase in the cost of nursing is considerably below the increase in cost of living in general.

I think that I have given you sufficient facts to show that, in spite of the howl about the high cost of sickness, the cost of sickness has not increased in the same ratio as have other necessities of life, to say nothing of the luxuries. I know families in this city who spend more money per annum in movie picture shows and theaters, or patent medicines and nostrums than they do in scientific and legitimate care of sickness, and usually before they consult their regular family physician. The necessities of life are generally recognized as being food, clothing, shelter and care in sickness. It surely would be interesting to make a comparative study of the cost of the necessities of life with the cost of luxuries of life in our United States.

COSTS OF GOVERNMENT

Our barons of industry who are so solicitous about the cost of sickness, how solicitous are they about the high cost of living in general when on their way to Washington in order to secure from Congress an increase of tariff rates on their industry and manufactured products? What about the cost of Government? This surely is a question the public should be interested in and should attempt to control. In 1890 the cost of our State Government was $1,958,126.12, while the biennial budget approved by the Legislature now in session is approximately $42,000,000. The Legislature now in session in this State has spent three-fourths of its time in devising and enacting ways and means of increasing taxation, and the public seems to like it. In 1900 with a population of 75,994,575 the cost of our Federal Government was $520,860,847 while in 1931 with a population of 122,775,546 the cost will be $4,120,000,000, an increase of about 800%. What does this mean? It means that while the population of the United States increased only about 75%, the cost of Government increased about 800%.

I think I have proved to you by conservative facts and figures that the cost of sickness has not nearly increased to the same extent as the cost of other essentials of life have increased; that the cost of sickness has not nearly increased in the same degree that the wages and salaries of those most concerned have, and that the cost of sickness has in no way increased as much as the cost of Government has.

Secretary Wilbur, in a recent article in the magazine section of the Milwaukee Journal, made a tentative report based upon the findings of a five-year investigating committee. This investigation into the high cost of sickness is a laudable effort and may give us valuable information. Unless, however, this investigation is a comparative one, it will be of little or no value. Any investigation of this kind must take into careful consideration the time we live in, the cost of living in general, especially the cost of the necessities of life of the same period, and a comparison of the cost of sickness with the luxuries of life.

Secretary Wilbur in this article suggests co-operative medicine as a solution. His principal suggestion is the formation of clinics, and he hopes in this way to reduce the high cost of sickness. I am firmly of the opinion that this is not a solution of the problem. He freely admits that the medical profession is at present inadequately remunerated for their services. Is the formation of clinics in any way going to increase the income of the medical profession and at the same time reduce the cost of sickness? It certainly will not. To-day the cost of a complete examination and the rendering of medical and surgical service in the large clinics

of this country is higher than it is outside of these clinics. In the clinics the patient demands examinations and is given them that are in no way necessary in arriving at a correct diagnosis, thereby increasing the cost of examination. Undoubtedly there are certain advantages in the clinic,—in the first place, the patient can get a complete examination in the same place and is not obliged to consult various special workers in different offices. In the second place, there is more ready and efficient correlation of the facts and findings in the case, and in the third place there are more prompt and frequent consultations regarding the case than can be secured outside of the clinic. In this way the clinic may be more efficient and time saving but my fifteen years of experience in clinic work does not convince me that it is in any way cost saving.

PREVENTIVE MEDICINE

Instead of investigating the high cost of sickness, would it not be better and more interesting to determine whether or not the total amount of sickness is being reduced, whether or not the duration of sickness and hence the economic loss is lessened, whether or not if sickness does come it is less frequently fatal and the suffering from sickness and injury is relieved?

Then there is another important question. How much money is expended annually to prevent sickness? Prophylactic and preventive measures in the form of serums and vaccines are being used daily by physicians. This is surely not a cost of sickness, but an insurance against sickness, and cannot be tabulated with the cost of sickness.

Secretary Wilbur says the cost of sickness in this country is $6,000,000,000 annually, an estimate much higher than previous estimates have been. It is not quite clear from the article whether this sum is solely for medical services, hospital and nursing, or whether it includes patent medicines and services by irregulars and quacks. In the Journal of the American Medical Association of May 31, 1930, Dr. W. C. Rappleye, gives us the following comparative table: The annual cost per family, per year for patent medicines and drugs is $25.00, physicians $24.00, hospitals $15.00, nurses $8.00, dentists $6.00, irregulars $2.00, automobiles $150.00, tobacco $67.00, candy $37.00, theaters and movies $35.00, soft drinks, ice cream and gum $34.00, jewelry and fur articles $29.00. I am sure if it were possible to even approximately estimate the amount of the liquor bill in the United States the result would be staggering.

Dr. Rappleye's total cost of sickness including patent medicines, drugs, physicians' and surgeons' fees; hospital, nurses' and dentists' fees, fees of irregular practitioners is $2,130,000,000 or $80.00 per family, a figure much below that of Dr. Wilbur's. This is non-governmental service.

Let me ask you this question: Do you think that anybody should complain of the high cost of sickness when the American people spend hundreds of millions of dollars more for tobacco than for legitimate medical service, as much for amusements in general as for sickness, as much for face powder, rouge, lipstick, perfumes and other cosmetics as we do for sickness? A few days ago, Secretary Mellon made the statement that it is absolutely essential that the high standard of living of the American people be maintained in order to insure a return to prosperity. Doctors and nurses are American people, why should their standard of living be lowered in order to maintain the high standard of living of the rest of the citizens?

Total the cost of luxuries of the American people and the cost of sickness will not seem large in comparison.

THE SOLUTION

No one should attempt to criticize conditions which do not seem right to him without offering some solution. To me it appears that the solution lies in two directions: In discussing a plan of relief, society must be divided into three groups—the wealthy, the middle class and the poor. The wealthy are well able to care for themselves when sick and they should not complain of graduated fees for medical services, as in this way they have an opportunity to contribute very materially to the care of the middle class for which they principally express their solici-

tude. As far as the poor are concerned, they, in sickness, are provided for in a most satisfactory and liberal manner by our county hospitals, asylums, county dispensaries and the charity of the medical profession. Our poor in Milwaukee County, for instance, receive medical, hospital and nursing care as promptly and efficiently as the wealthy can receive in private hospitals or sanitariums. A surgical nurse at the County Hospital told me that during the month of January of this year there were 480 operations performed at this hospital. Figure out for yourself what this means to the medical profession and the poor of Milwaukee County.

The wealthy and also the poor being well cared for in sickness, we have to deal only with the middle class, those in moderate financial circumstances, and right here among this middle class much can be done to make the cost of sickness less burdensome.

The American public, especially the middle class, during the last 15 years has indulged in an orgy of spending never before experienced. Even if there were a family budget, no provision was made in it for sickness, which every one knows will surely come. If this same middle class would realize that sickness and death are inevitable and provide for it by laying aside in some secure investment enough to take care of it when it comes there would be less dissatisfaction, grief and misery.

Many years ago my practice was largely among the German immigrants of the north side of this city. These thrifty people, although they knew nothing about budgeting, always saved something to cover the cost of sickness, and when sickness came they were very happy to part with this portion of their savings in consideration for a return to health.

Sometime ago the suggestion was made in the daily press that if every individual in this country would spend 15 cents more each day, the depression from which we are suffering would be lifted. I am not economist enough to deny this, but I am firmly of the opinion that the suggestion was economically an unsound one. Big business and industry are daily advising the wage earner to spend his wages in order to keep turning the wheels of industry. But what happens to the wage earner when he gets sick or is unemployed, or is no longer fit to do a day's work? He becomes a pitiable object of charity or a public charge. If he had saved some of his earnings for a period of sickness or unemployment, or for the time when he is unfit to work there would be rejoicing and the wheels of industry would be turning more securely and permanently. To my mind there are three individuals in this country who are doing much to encourage thrift and a return to sound economic principles. They are Calvin Coolidge, Will Rogers and the Old Counselor of Halsey, Stuart and Co. Let us hope that the American public will heed their advice and gradually bring about a return to a sound and stable social and economic status. If the middle class cannot be persuaded to save a part of their earnings for sickness, why not provide for this unavoidable expense by health insurance. A man will insure his house against fire although he does not know or expect to burn down. Why should he not insure his family against sickness which he knows will surely come.

It is stated by reliable authority that approximately 76% of the wealth of this nation is in the hands of 4% of the population; also that there are 405 individuals in this country whose annual income is over one million dollars. The cost of sickness cannot be reduced by reducing the income of the doctor or the nurse. The only way in which the cost of sickness can be reduced is by reducing the hospital expense. Why do not these multi-millionaire foundations endow our hospitals. They are building and endowing educational institutions every where. Many careful students of affairs are beginning to question the advisability of universal opportunity for collegiate education. For the intellectually fit it is a blessing, as they are destined to become the leaders in science, industry and culture. The intellectually unfit are often lifted out of the sphere in which they properly belong where they might become useful citizens, into a plane where they

are a menace to society. An endowment of $5,000,000 would enable any hospital to materially reduce the cost of sickness, and I am certain such an institution would gladly submit to control of their hospital rates by the donors. Surely the health of the nation is no less important than the education of the nation.

The Art and Practice of Medical Writing*

By MORRIS FISHBEIN, M. D.
Editor, Journal of the American Medical Association
Chicago

The Editorial Board of the Wisconsin Medical Journal considers itself particularly fortunate to be able to present this lecture as the first of four to be published in consecutive months. The lecture here presented was preceded by others which served to introduce the course.

The Bibliography

The teacher whom I had in pathology had a plan for accumulating material for scientific papers which he proposed to write at some future date. He was economical. He took each of the envelopes which he received in correspondence, cut off the outside and saved the inside. These slips fit exactly into a pigeon hole file. Whenever he had a subject under consideration for future publication,—and he usually had three or four,—he assigned a pigeon hole to it. Then as he read medical literature he made notes concerning each article on one of the slips and deposited it in the pigeon hole. When he began to write his manuscript it was necessary only to arrange the slips in proper order.

Another teacher who is a competent writer kept a loose-leaf notebook and had divisions assigned to various subjects which he proposed to discuss in the future. This plan I follow in the preparation of lectures and literary contributions. This notebook is indexed at the top of each page. It is simple to keep the notes on these sheets of paper, to number them consecutively as to their place of interest in the final manuscript. When one comes to write the manuscript it is necessary only to arrange the references and then to rewrite from them.

The average physician, in giving birth to some literary conception, adopts the following procedure: He waits until the night before the meeting is to be held, then goes home and tells the family that he cannot be disturbed, locks himself in a room, looks up such text books as he may happen to have and spreads them all out on the table, open at the proper page. Then he sits down and begins to write. He reaches over and gets one of the books which covers material which will fit in at some particular point. Those who propose to write regularly ought to have a systematic technic for working up material. Experienced writers, both in medical and other fields read their material carefully, make notes, and then let the material rest in their minds before writing anything. If one has an orderly or scientific mind, and can mentally arrange the material after the passing of a reasonable amount of time, one can sit down and write, telling what one really knows rather than just repeating reference material.

Most courses in English composition teach the students the system of taking notes on cards and arranging the cards to correspond with the outline developed, and then writing according to the outline. In the outline system one usually begins by making a large capital "I" or "1" and writing, "Introduction," and after that "History," and after history, "Past History." After this, one will perhaps follow the Osler arrangement of "Etiology," "Diagnosis," "Pathology," "Epidemiology," "Differential Diagnosis," "Prognosis," "Prevention" or "Prophylaxis," and "Treatment." The majority of medical periodicals no longer care to present consideration of disease in this manner. They prefer that the writer present a brief background for his subject and then contribute the material actually his own. The history of diseases has grown to such an extent, and the book and periodical literature are so extensive, that it is no longer feasible to present repeatedly such a complete consideration.

In a batch of manuscripts which I took home for reading over the week-end, I found six covering agranulocytosis. Obviously, if I were to accept all six manuscripts I would not want each man to cover the subject completely. Four of the papers were returned. One which was accepted described a case exceedingly unusual in all its aspects. The others which were returned concerned cases with the usual course.

Assuming that you have collected much material, you prepare a systematic outline with introduction, body, summary, and conclusions. Your introduction will state your reasons for taking up the consideration of the subject, with a brief amount of history and a background of bibliography. The summary should summarize briefly all the important points brought out in the manuscript, and the conclusion should not repeat the summary. The conclusion should state the new opinions that may be derived from the evidence.

The making of an outline is simple.

I. Introduction.
  (A) Reasons for presentation.
    1. Previous views.
    2. Current contributions.
      (a) Schmidt.
      (b) Weber.
    3. Author's opinion.

II. Body.

* Presented as one of a series of lectures offered under the joint auspices of the Medical Society of Milwaukee County and the Extension Division, University of Wisconsin, in Milwaukee, 1931.

BIBLIOGRAPHY

Every subject in medicine today has an extensive background. Consider the treatment of pernicious anemia with liver. In the past five years over a thousand references to such treatment have appeared in scientific literature. Few magazines will care to reprint a recapitulation of this literature.

In the magazine "Medicine," are published monographs on topics, such as "Hypotension," "Hypothyroidism," and "The Effect of Light on the Human Organism." The authors look up every available scientific reference. "Physiological Abstracts" publishes similar material. After looking up all the references which bear on the report, you yourself may make a wise selection.

There are available at the present time many works of reference and indexes. Begin with the Index Catalogue of the Library of the Surgeon General's Office at Washington. It has been issued in three series. The third series is just being finished. This was conceived by John Shaw Billings and carried on after him by Fielding Garrison, and others. It covers all the medical material in the library at Washington, classified and indexed.

In looking up "The Bacteriology of Peritonitis," in 1912 I did it in this manner: I went first to the Index Catalogue of the Army Medical Library, and looked up peritonitis. There I found it reclassified into surgery, bacteriology, pathology and similar headings. Under each of those headings were references to books and periodical literature. I went to the periodical literature and found many references to the bacteriology of peritonitis. Obviously I could find no literature on the bacteriology of peritonitis previous to 1878 because knowledge on that subject begins with the time of Pasteur. There was no use in going back previous to the time of Pasteur. In the *Index Medicus*, an index to current literature, I found the material classified under large headings, such as "Pathology," "Bacteriology," "Surgery." I looked through the author index and carefully ran down the subject references. After going through all the literature from 1880 to 1905 I suddenly came upon a reference to a paper by a man named Dudgeon, a well known British bacteriologist. I looked up his paper and found that he had carefully done what I was doing. He had summarized all the literature on the bacteriology of peritonitis. I wrote, "In 1905 Dudgeon carefully summarized all the previous literature on this subject. Since then the following studies have been made." Then it became necessary for me to find literature since 1905.

Practically all physicians take the Journal of the American Medical Association. It has a Current Medical Literature Department. In this Current Literature Department articles of importance in the leading magazines are listed, and many are abstracted. In the last issue for June and December of each year there is published a complete subject and author index. Therefore, in tracing back the literature for the previous fifty years, in case you do not want the complete literature but only the important literature, consult the semi-annual indexes which appear with the volumes of the Journal of the American Medical Association. For presentations before county medical societies or before state medical meetings, such recapitulations of the literature are usually adequate.

About 1899 Virchow published a series of articles on medical writing. I found these classical. He was a great master in his field and a great editor. He paid special attention to system and to originality. He mentioned particularly the way in which one author will copy from another; the way in which one author would pick up another's material and cite it as his own without saying where he got the abstract. This type of literary theft is not only unethical but it is also unscientific. It is not fair to put in as your own any reference which you have not looked up. If you adopt an abstract, reference should be made not only to the original article but to the abstract. In giving a reference to an article, you should give the name of the author, the volume and page, or, as we do in the Quarterly, the volume, page, number and year, and after that, "Abstract: Journal of American Medical Association, volume, page, month and year" in the same way, so that anyone who reads it will understand that you are referring to the abstract.

This should be done also in referring to a citation in an article by an author to some literature that he has looked up. Today an assistant editor brought me a long article on "Ophthalmology." Our editors endeavored to check the reference and found it inaccurate. We wrote to the author asking him to locate the reference. He replied that the reference was not his,—that it had been taken from a book. We located the book and looked up that reference in the book. We wrote to the author of the book and got a letter from him stating that it was not his reference. Finally we found that the reference in the book was wrong by two years. We spent much time trying to check the reference. If we had printed the article in one of our publications some one else might have spent many more hours in an effort to check the reference.

Most modern medical periodicals have good indexes. Therefore, in writing on children's diseases, dermatology, surgery, and so forth, consult the indexes, volume after volume, going back for ten years, in order to find previous references. For instance, in the American Journal of Diseases of Children, years ago, we published a monograph by Dr. Park of the Johns Hopkins Medical School. This covered all the literature concerning the thymus. Since that time it has been unnecessary for succeeding writers to recapitulate. We expect merely that they will go back to Park and bring his material up to date.

Now you have your notes; you have your references; you are ready to begin the writing of your manuscript. I presume most of you are sufficiently affluent to employ a stenographer. The stenograph-

er will type or you will sit down and write. Few publications will accept manuscript that is handwritten, manuscript written on both sides of the paper, mimeographed copy. Many authors have their material mimeographed and hand out copies, feeling that the hearers can follow while they read. The editor prefers the original manuscript written on one side of the paper only, and in double or triple spacing.

PRESENTING THE MANUSCRIPT

In presenting the manuscript certain forms must be followed. It is the tendency of most doctors, being economical, to write near the top of the first page. A large upper portion of this page should be blank. That space is important to the editor. First put the title of your paper, then your name and address. Presume that you have a footnote indicating that you have read the paper before some special society. Put an asterisk after the title to indicate that there is a footnote.

When the manuscript editor receives the manuscript it is necessary for him to put many instructions at the top of the page for the printer's attention.

Let us suppose that the manuscript is an original article. A statement as to the nature of the material will be written by the manuscript editor. Then he will want to note how many illustrations are to be used, how many charts, how many tables, etc. All this must be written at the top of the page. For instance, 6 halftones, four zincs, three charts, five tables, Rogers type. Then there will be catch lines set in large type conveying instructions to the make-up men and the compositors, the assistant editors, and others. A catch line, for instance, will be: "Extra page follows." It is always best to allow plenty of room on the first page for the editor. He may be so happy over the fact that he has an intelligent author that he will take the paper.

Leave lots of room between the lines, an inch and a half on this side, an inch and a half at the bottom, and an inch and a half on that side, of every page. When the editor corrects manuscripts, he needs plenty of room for the transfer of words, the correction of misspellings, and so forth. Much space is needed between the lines, on the sides, and at the bottom of the page. If the manuscript is written in single spacing, every correction must be made in the outside margin, whereas if there is a lot of room between the lines, corrections may be inserted between the lines. Number the pages. Study the mechanical aspects of your manuscript.

MANUSCRIPTS

Here is a manuscript entitled "Chororetinitis," with the author's name. The title appears in the proper place except that there is no period after it. The article begins too high on the page, and then it begins sharply: "July 29, 1930, Mr. E. H. complains of soreness of left eye, blurness at times." There is no verb and no preposition.

It should read: "On July 29, 1930, Mr. E. H. complained of soreness of his left eye, with blurred vision at times."

I take it that he did complain. That is entirely different from another paper which I have here in which I am quite sure the patient did not complain. It reads:

"R. C., a white female, age seventeen months, admitted to the Children's Hospital with the complaint of vomiting."

At seventeen months of age I doubt if she could complain of vomiting.

In a case report tell the story the same as you would describe a fishing or a hunting trip. It is not always necessary to say, "The patient came here. He was referred by so and so" and then go on with the history, the physical examination, the laboratory examination, the diagnosis, operation, pathological examination, post mortem, and the conclusion. Sometimes it is quite unnecessary to give all these details.

Here is a report which says: "History: one week ago at work while closing a window, a piece of glass flew into the left eye." I have particularly warned against the confusion of time in a scientific report.

This one says: "July 29, 1930, Mr. E. H. complained of blurred vision." The report was written in September, and will be published next May. Then the reader seeing "one week ago" is taken back to a week in April. What the author means is one week previously to July 29," or "On July 22, while at work, when closing a window, a piece of glass flew into the left eye."

The author continues: "Initial examination negative. Deposits removed," throwing in the latter phrase as a parenthetical statement.

The following would be better: "Initial examination was negative, externally, except for a slight irritation due to calcium deposits, which were removed."

Here's a paper entitled, "Spontaneous Pneumothorax." The manuscript lacks the name and address of its author.

This one begins, "White male student, always has been considered a man of good habits." The sentence should read: "A white male student, age 21, considered healthy and with negative parental history . . . . "

It is not correct usage for a noun to be used as an adjective. "No tuberculosis history," should be "No tuberculous history." Again may I emphasize that the word "tubercular" refers to nodules and the word, "tuberculous" refers to any lesion caused by the bacillus of tuberculosis. It is important that this distinction be noted, particularly as many medical writers confuse the terms. He says, "Present illness consists of. . . . His physician stated that he had a spot on his lung. November 19 he spent in Chicago with little discomfort." That's unusual in Chicago.

"November 22 he reported back to his physician. His chest was strapped and later a mustard plas-

ter was applied, without relief. He remained in bed, still having some distress. November 28 he reported to his physician that he had a third attack. He was treated with ice bags to the side. He came to Milwaukee and was examined at my office. He appeared to be a well developed male."

That is written in telegraphic form. Rewritten in English:

"His physician stated that he had a spot of pleurisy about the size of a dollar. Under local treatment the pain subsided the following day. He spent November 19 in Chicago. On November 22 he reported back to his physician, stating that he had severe pain. His chest was strapped and a mustard plaster was applied without relief. He remained in the hospital until he was discharged on November 26, although he was having some distress. On November 28 he reported to his physician for a third time, again on account of pain on exertion, and was treated with ice bags to his side. He came to Milwaukee, and I examined him in my office."

A CASE OF CEREBRAL HEMORRHAGE

The author gives his name but he takes it for granted that he is so well known his address is unnecessary.

He begins: "Cerebral hemorrhage occurring early in life that occurs as the patient advances in years is not considered a proven fact."

You will find it much to your advantage to read a marvelous book written by Sir Thomas Clifford Allbutt, Regius Professor of Medicine, recently brought out in a third edition, and I think one of the best books on medical usage that I have read. You will enjoy reading it as a medical classic if for no other reason, but it is philosophical as well. Sir Thomas tells us that there is no word so misused in medical writings and findings as the word "fact." A doctor will say, "It is a fact." "It is a proven or established fact." If it is a fact it has been proven and established. You will find an excellent discussion of this and other misused words and phrases in Sir Thomas' work.

I have referred to the use of such phrases, signs, and symbols as the Romberg sign, the Babinski phenomenon, and the Argyll Robertson pupil. Almost every nation claims that it was the pioneer with regard to what has been accomplished in connection with goiter, which is called by a half dozen names. This author says that the Macewen sign was positive. How many here know what the Macewen sign is? Four men know what the Macewen sign is. Such signs or reactions should be described. There are also the Wassermann test, the Kahn test, and the Provocative Kahn test. How many know what is meant by each of these? The last has not even been announced.

Here is the report of an exceedingly interesting case of trichinosis, having no author or address.

This begins: "July 10, 1930, an unmarried woman, a cook in a Jewish family, forty years of age, had fallen ill on the preceding day." I have spoken before, I believe, about the sociologic background of the patient. Pork, ordinarily is not eaten in a Jewish household; therefore, this is exceedingly interesting data. But the reader does not know the racial history of the cook. The family might have bought pork for the cook. In that case the history of the family was unnecessary.

"The family showed nothing unusual." That avoids the use of much unnecessary language. For instance, in a case of trichina it would be unnecessary to say that the patient had diphtheria, measles, or scarlet fever, but if you were reporting a case of acute rheumatic fever or a case of arthritis it would be important to recite that four years previously the patient had scarlet fever. The streptococcus infection presumably would be associated with that illness.

Most doctors have alarmingly small vocabularies, so they will say, "showed" repeatedly. That word has many synonyms. You can buy a Roget's Thesaurus which I am sure will prove of assistance to you. You can say, "The patient revealed," "Examination indicated," "Observation brought to light." It is well not to repeat the word again and again. You can say "The microscopic findings were," or "The physician's observations were."

"The respiratory tract showed no pathology." It would be better written, "Pathologic changes were not seen in the respiratory tract." He says, "The cardiovascular system . . ." "Abdominal findings were negative." It would be much better to say, "Nothing significant was observed in the examination of the abdomen."

"Case Report: Intestinal Obstruction.—R. C., white female, eighteen years of age." That should read: "R. C., white girl."

This case report of carcinoma: "May 7, 1921." (It is not well to begin with a date.) "A. G., a farmer, age 47, complains of hoarseness." I want to emphasize particularly that most of the corrections on this manuscript have to do with the changes of tense in the verb. This case report reads, "The patient came in complaining of hoarseness. He is unable to talk." Here is an incorrect change in the tense of the verb. Describe everything that happened in the past tense and then come down to the present from that time on, or, if you are describing a case examined six months previously, go back to the remote past, then to the past and on down to the present. The author says: "On May 7, 1921, the patient complains of hoarseness which gradually grew worse."

It should read: "A. G., a farmer, age 47, was seen on May 7, 1921. He stated that he had been suffering from hoarseness for the past five years, which had been gradually getting worse. He could not speak above a whisper. He had had various sorts of treatment, mostly with medicines advertised in newspapers."

The author says, "He was given several injections in the arm during this time." He means to

say: "He was given several injections into the veins in the arm, and had taken potassium iodide." He used the abbreviation, "K. I." K. I. should be written potassium iodide.

The manuscript continues, "He requested an immediate operation. He could not whisper and wrote his wants on a pad. He left the office and did not return. I heard indirectly that the patient died in 1922." The last sentence would be better written, "Information was received indicating that the patient died in June, 1922."

The essential corrections can easily be made by going over the manuscript and revising again and again.

"Leukocytosis." This manuscript bears no address, but the author provides an introductory paragraph. "The phenomenon, leukocytosis. . . ." "A case in this field that may be called unusual is sufficient reason for the following report." Outside of that introductory paragraph it is a fine manuscript, except for the common error in the use of the phrase, "the above case." A short review of definitions at this point will be of some assistance. In the first place, he speaks of "the above case." When that is printed the sentence may be above the case to which it refers. So the use of the word "above" in general is wrong. What the writer means is "the foregoing case report," or he should in some other manner refer to the case already described. He needs merely to say, with regard to the other sentence, "A short review will be of some assistance," which is what the author does, and very well. He finishes with a conclusion. A two-page paper requires no conclusions unless they are of great importance.

This was a case report of a blood transfusion and the purpose of the report was to show the necessity of tests for compatability before the transfusion.

This paper does not carry the author's address, but he speaks of a human being as a male individual which dignifies him entirely too much. He is, after all, a man. I have told you before that a case report must convey a picture. No man, in 1930, would be a male individual and walk into your office asking you if he had been permanently disabled. Can you picture a man walking into your office and saying, "Doctor, have I been permanently disabled?"

The patient stated that he had gas disturbance after eating.

"He complained of loss of weight and loss of appetite. He complained that he was becoming nervous and was unable to work." It would be better written, "He complained of loss of weight and appetite." You can drop one of those losses. He again did too much complaining. This is all a part of the history. The patient had a loss of this and a loss of that. The history of the present complaint: I am emphasizing these complaints because five complaints appear within ten lines. If you emphasize the complaints too much you may get a picture of a much sicker man than is correct. Try to avoid the use of the lengthy sentence. Short, affirmative statements will carry the picture much better.

Here is a report with the usual telegraphic information:

"He was trembling as he gave his report. He stated that he had a loss of twelve pounds within six months. No teeth infection. No apparent thyroid. Blood pressure: 178."

This might be rewritten:

"A physical examination revealed a nervous man, trembling as he gave his report." He was frightened. That is a good picture. "He weighed 130 pounds which he stated represented a loss of twelve pounds in six months." The doctor didn't know, so you will say, "He stated." Patients will say they have lost sixty pounds when in fact the weight actually lost will be only twenty pounds.

"There was no evidence of eye, ear, nose, or throat infection. Eye reflexes were normal. A careful physical examination revealed. . . ." I have spoken previously about the examination of every possible organ and tissue and writing thereafter, "negative." It is all sufficient to say merely, "The examination of all the other organs revealed nothing of importance," which indicates that you actually did examine them. Or, you may say, "Careful physical examination revealed nothing unusual except for a leukocyte count of . . ." That is important. "An x-ray examination also failed to reveal any disturbance, and the gastric disturbance indicated no pathology." Pathology is used wrong. "Failed to reveal" gives a better picture.

"A final diagnosis of neurosis was made. He was told to return to light work. When seen in August, 1930, he had gained ten pounds and practically all his original symptoms had disappeared."

Over Three Hundred Attend Extension Centers on Insulin Use

During the week of May 18 the University of Wisconsin Extension Division conducted a unique series of clinical conferences in six cities of the state. In Madison, Milwaukee, Oshkosh, Wausau, Eau Claire, and La Crosse there were 310 doctors who spent five hours in an intensive study of the accepted and most recent methods for the treatment of diabetic patients. The instruction was provided by Dr. Leland S. McKittrick of Boston, Dr. E. L. Sevringhaus of the Wisconsin General Hospital at Madison, and Dr. Russell M. Wilder of the University of Chicago. One of the most valuable parts of the afternoon was the description and dem-

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PRESS SERVICE OF STATE MEDICAL SOCIETY

No serum does so much for public health as printer's ink

THE HOUSEFLY

Madison, Wis., May 27.—The killing of a housefly today may prevent the death of a baby from typhoid this summer.

The time to swat the fly is now when it is breeding its millions. The way to eliminate the fly is to destroy the infested places where it breeds. In the words of Walt Mason:

"The early fly's the one to swat,
It comes before the weather's hot.
It sits around and cleans it legs
And lays almost a million eggs.
And every egg will hatch a fly
To drive us crazy by and by."

Wisconsin's campaign against flies and the elimination of the polluted sources of water supply are hailed by the Health Committee of the State Medical Society as the two big agencies which have reduced the typhoid rate in Wisconsin to one of the lowest in the nation.

"The fly breeds in the garbage can and lives in filth and then people still wonder why it is that the common housefly has become such a menace to the health of the babies of the nation," declares the Medical Society's warning. "The fly plays around where the typhoid and other disease germs abound. On its feet and legs it carries the disease and filth which brings disease and suffering to mankind and its children.

"Scientists have calculated that the progeny of a single pair of flies, during the active season, is about 195,312,000,000,000. Now just suppose that some dutiful citizen wanted to better the health of his community by swatting the fly. If he had an indestructible swatter and an untiring arm and killed an average of one fly every ten seconds for twenty-four hours a day, he would have accounted for just 8,640 flies. In just 6,193,303 years he would have finished off the last of the progeny. Of course, many other progenies would have lived and died before that. If he had prevented that pair of flies from breeding he would have saved himself a lot of work and would have led a more useful life.

"Now is the time to rid the home and surroundings of flies and filth. Sunshine and health will take the place."

* * *

FOOT DEFORMITIES

Madison, Wis., June 3.—Many children with clubfeet could have been cured a few days after birth if given immediate attention, the State Medical Society declared in a bulletin issued today. For several months, officials of the Medical Society have been gathering complete information regarding deformities in children's feet and discovery has been made that many of these could have been cured at birth.

"The infant's foot, if there is no deformity present, requires merely bathing, and the application of a dusting powder," declares the bulletin. "If there is a club foot, parents should not wait until the child is a year old but should have treatment started immediately, even the first day of life.

"It is important that the baby's stockings and shoes fit properly. Fat babies should not be encouraged to stand too early for fear of causing bow legs or knock knees. Stiff ankle shoes, that is, reinforced with moulded leather, are of value in some cases of weak feet. Many parents with a laudable desire to keep white stockings clean have them washed frequently, and although the stockings are dried over 'forms' they often shrink and are a source of foot compression.

"In adolescence, the foot is growing very rapidly, and, as it is usually long and narrow, requires special attention in fitting shoes.

"A common complaint among the aged is poor circulation of blood in the lower extremities. If those past middle life will spend an hour, each morning and afternoon, with their feet elevated on a chair or stool, they will be aided.

"Persons recovering from an infectious disease, such as tonsillitis, influenza or scarlet fever, are apt to go about the house in bedroom slippers. This is an extremely bad practice, for at this time the supporting structures of the foot are relaxed owing to the toxemia of the infection."

* * *

WALKING

Madison, Wis., June 10—Those who do a little walking now will prolong their days, according to a bulletin issued by the Educational Committee of the State Medical Society. The bulletin endorses walking clubs and golf and all sorts of exercise that will bring people out-of-doors. It declares that sunshine and exercise can add more years to a person's life than any doctor's prescriptions.

Too many tourists see the world from an automobile seat and too many people go to school and to work in an automobile, according to the report. That much of the sleeplessness at night is due to a lack of exercise is one of the predominant notes in the Medical Bulletin.

"Thousands of men and women have fallen into the poor woman's mode of living. They ride everywhere, to business, to theater, to church, to market. They are whirling themselves quickly toward their last ride," declares the bulletin issued today.

"Many children, especially those living in cities and suburbs, are being brought up as if they were helpless cripples. They are driven to and from school even when they live only three or four blocks away. They are driven to music lessons, to dancing classes, to parties, to the movies. The tempo of their life is so swift that they have not time to walk, to loiter, to dream.

"Look at the residence streets of any town or suburb; the sidewalks are practically deserted. In many New York suburbs there are no sidewalks outside of the business streets. No one would use them, so why build them? 'Ride and the world rides with you, walk and you walk alone.' As for any group of adults starting off on a long Sunday hike in the East—well, such people are considered just a little mad by the folk who whirl past in closed cars. But the walkers are having the best of it just the same.

"Walking remains the cheapest, most delightful, most healthful form of exercise. Any one who is not a bed-ridden invalid can walk outdoors a mile a day and benefit by it. And nearly every man, woman and child in the land could find time to walk that much if he planned his day with commonsense forethought.

"Too many tourists see the world from an automobile seat. Roads have been built nearly everywhere, but it is still true that the hiker who goes out on the trails sees far more than the autoist who rides the roads. And he has a better time. Sleep after a day of arduous climbing and hiking is better than sleep after a day of driving a car. There is a certain strain about driving over even good roads, but there are relaxation and rest in the rhythm of walking."

(Continued on page 600)

THE JOURNAL BOOK SHELF

Cancer. Its origin, its development and its self-perpetuation. The therapy of operable and inoperable cancer in the light of a systemic conception of malignancy. A research by Willy Meyer, M. D., consulting surgeon to the Lenox Hill and Postgraduate Hospitals, New York Infirmary for Women and Children, etc., emeritus professor of surgery, N. Y. Postgraduate Medical School. Price $7.50. Paul B. Hoeber, Inc., New York, N. Y.

Recent Advances in the Study of Rheumatism. By Frederic John Poynton, M. D., F. R. C. P. (London). Physician, University College Hospital; senior physician, Hospital for Sick Children, Great Ormond St., and Bernard Schlesinger, M. D., M. R. C. P. (London). Physician to Children's Department, Royal Northern Hospital. 25 illustrations. Price $3.50 net. P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia.

Traumatotherapy. By John J. Moorhead, B. Sc., M. D., professor of surgery and director, department traumatic surgery, New York Post-Graduate Medical School and Hospital; surgical director, Reconstruction Hospital Unit; colonel medical officers reserve corps, U. S. Army. 574 pages with 625 illustrations. Price $7.00. W. B. Saunders Co., Philadelphia and London, 1931.

Piersol's Human Anatomy. Including structure and development and practical considerations. 9th edition revised, under the supervision of G. Carl Huber, M. D., Sc. D., professor of anatomy; director of anatomic laboratories and dean of the graduate school, University of Michigan. 1734 illustrations. J. B. Lippincott Co., Philadelphia.

Surgical Pathology of the Diseases of the Bones. By Arthur E. Hertzler, M. D., surgeon to the Agnes Hertzler Hospital, Halstead, Kansas. Published by the author.

Physical Examination and Diagnostic Anatomy. By Charles B. Slade, M. D., formerly chief of clinic is general medicine, University and Bellevue Hospital Medical School, New York. Fourth edition, thoroughly revised. 12 mo. of 196 pages with 43 illustrations. Cloth $2.00 net. W. B. Saunders Co., Philadelphia and London, 1929.

Symptoms of Visceral Diseases. A study of the vegetative nervous system in its relationship to clinical medicine. By Francis Marion Pottenger, A. M., M. D., L. L. D., F. A. C. P., Medical Director, Pottenger Sanatorium for Diseases of the Lungs and Throat, Monrovia, California; Author of "Clinical Tuberculosis," "Tuberculin in Diagnosis and Treatment," "Muscle Spasm and Degeneration." Fourth edition. with 87 text illustrations and ten color plates. Price $7.50. C. V. Mosby Co., St. Louis.

Crippled Children. By Earl D. McBride, B. S., M. D., F. A. C. S. Instructor in orthopedic surgery. University of Oklahoma, School of Medicine; attending orthopedic surgeon to St. Anthony Hospital; associate orthopedic surgeon to Oklahoma City General and Wesley Hospitals. Price $3.50. C. V. Mosby Company, 3523 Pine Blvd., St. Louis, Mo.

Obstetrics. A textbook for the use of students and practitioners. By J. Whitridge Williams, professor of obstetrics, John Hopkins Hospital, Baltimore. Sixth enlarged and revised edition. With 17 plates and 730 illustrations in the text. D. Appleton & Company, New York and London.

Physical Therapeutic Technic. By Frank Butler Granger, M.D., late physician-in-chief, Department of Physical Therapeutics, Boston City Hospital; assistant professor of Physical Therapy, Tufts Medical School. With a foreword by William D. McFee, M.D., Boston, Mass. Octavo volume of 417 pages with 135 illustrations. Price $6.50 net. W. B. Saunders Company, Philadelphia and London, 1929.

Selections from the Papers and Speeches of John Chalmers DaCosta, M.D., LL.D., Samuel D. Gross, Professor of Surgery. Jefferson Medical College, Philadelphia. 440 pages. Cloth, $6.50. W. B. Saunders Co., Philadelphia and London.

Discovering Ourselves: A View Of The Human Mind and How It Works. By Edward A. Strecker and Kenneth E. Appel. New York: The Macmillan Co. 1931. 306 pages. Price $3.00.

BOOKS RECEIVED FOR REVIEW

Textbook of Histology. For medical and dental students. By Eugene C. Piette, M. D., pathologist and director of the Laboratory of the West Suburban Hospital, Oak Park, Ill. Consultant pathologist of the Chicago State Hospital, Chicago. With 277 illustrations, some in color. Price $4.50 net. F. A. Davis Company, Philadelphia. 1931.

Food Allergy. Its manifestations, diagnosis and treatment with a general discussion of bronchial asthma. By Albert H. Rowe, M.S., M.D. Lecturer in medicine in the University of California Medical School, San Francisco; chief of the clinic for allergic diseases of the Alameda County Health Center, Oakland; consultant in allergic and metabolic diseases, Highland Hospital; president of the Association for the Study of Allergy, 1927-28. Price $5.00 net. Lea & Febiger, Philadelphia, 1931.

Health on the Farm and in the Village. A review and evaluation of the Cattaraugus County Health demonstration with special reference to its lessons for other rural areas. By C. E. A. Winslow, Dr. P. H. Professor of Public Health, Yale School of Medicine. Price $1.00. The Macmillan Company, New York, 1931.

Diabetes. Its treatment by insulin and diet. A handbook for the patient. By Orlando H. Petty, A. M., M. D., F. A. C. P. Professor of diseases of metabolism, Graduate School of Medicine, University of Pennsylvania; physician in charge of departments of diseases of metabolism, Hospitals of the Graduate School of Medicine, University of Pennsylvania, and Philadelphia General Hospital; consultant in diseases of nutrition and metabolism,

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Shriners' Hospitals for Crippled Children, Philadelphia Unit. With illustrations and tables. Fifth revised and enlarged edition. Price $2.00 net. F. A. Davis Company, Philadelphia.

Eye, Ear, Nose and Throat for Nurses. By Jay G. Roberts, Ph. G., M. D., F. A. C. S., Pomona, Calif. Licentiate, American Board Otolaryngology; chief of staff, Eye, Ear, Nose and Throat, Los Angeles County Health Center; member staff, Pomona Valley Community Hospital; Author of "Bacteriology and Pathology for Nurses." Illustrated with 102 half-tone and line engravings. Price $2.25 net. F. A. Davis Company, Philadelphia, 1931.

White House Conference, 1930. Addresses and abstracts of committee reports. White House Conference on Child Health and Protection called by President Hoover. The Century Co., New York. 1931.

The Doctor And His Investments. By Merryle S. Rukeyser, B.Lit., M.A., financial editor, Medical Economics and Dental Survey; financial and editorial writer, New York American and associated newspapers; associate in journalism, Columbia University; Author, "Financial Advice to a Young Man," "The Common Sense of Money and Investments," and "Investment and Speculation." Price $2.50. P. Blakiston's Son & Co., Inc., 1012 Walnut St., Philadelphia, Pa.

Clinical Dietetics. A textbook for physicians, students, and dietitians. By Harry Gauss, M.S., M.D., F.A.C.P., instructor in medicine, University of Colorado, School of Medicine. Assisted by E. V. Gauss. B.A., formerly assistant dietitian, Presbyterian Hospital, Denver. Illustrated. Price $8.00. C. V. Mosby Co., St. Louis. 1931.

An Introduction To Gynecology. By C. Jeff Miller, M.D., professor of gynecology, Tulane University School of Medicine; chief of the Department of gynecology of Touro Infirmary; senior visiting surgeon, Charity Hospital, New Orleans. Illustrated. Price $5.00. C. V. Mosby Co., St. Louis, 1931.

The Infant Welfare Movement in the Eighteenth Century. By Ernest Caulfield, M.S., M.D. With 8 illustrations. Price $2.00. Paul B. Hoeber, Inc., New York, 1931.

Practical X-Ray Treatment. By Arthur W. Erskine, M. D. Price $3.50. Bruce Publishing Company, 2429 University Ave., St. Paul, Minn.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, 424 N. Charter Street, Madison, Wis.

Heart Disease. Paul Dudley White, M. D. Instructor in Medicine, Harvard Medical School. Physician, Massachusetts General Hospital, Boston. The Macmillan Company, New York, 1931, 931 pages, 119 illustrations.

This book, by a well known cardiologist, is comprehensive and represents a good balance between more or less theoretical consideration and concrete clinical application. The first part is concerned with methods, including a fuller consideration of cardiovascular roentgenology than is usual in books written in English. The second part takes up the incidence, causes and types of heart disease; the third part structural cardiovascular abnormalities, and the fourth part disorders of cardiac function. The work is concluded with an extensive bibliography of a hundred and eighty-eight pages and a short appendix tabulating the author's conception of the more important of the unsolved problems of cardiology. The book is beautifully illustrated and follows the usual high standards of Macmillan production.—J. A. E.

Clinical Diagnosis by Laboratory Methods. By James Campbell Todd, Ph. B., M. D., late professor of clinical pathology, University of Colorado, School of Medicine; and Arthur Hawley Sanford, A. M., M. D., professor of clinical pathology, University of Minnesota (Mayo Foundation); head of section on clinical laboratories, Mayo Clinic. 7th edition, thoroughly revised. 765 pages with 347 illustrations, 29 in colors. Price cloth, $6.00 net. W. B. Saunders Co., Philadelphia, and London, 1931.

This book needs no introduction to students of clinical medicine. It has long been one of the best texts of that branch of clinical diagnosis which is concerned with the application of chemistry, bacteriology, pathology, physiology and microscopy to the recognition of abnormal or disturbed body functions. Since the first edition clinical pathology has risen from a little noticed technical subject to equal rank with other recognized methods of clinical diagnosis. During this time this book has been re-edited many times. The authors are to be congratulated for thus preserving the life of a useful book. This edition contains many new methods and new interpretations of old ones. Medical students will find this book an up-to-date text on clinical laboratory methods and physicians will find it helpful in the interpretation of the results of laboratory examinations. W. D. S.

Hemorrhoids, The Injection Treatment and Pruritus Ani. By Lawrence Goldbacher, M. D., Philadelphia. Illustrated with 31 half-tone and line engravings some in colors. Second revised edition. Price $3.50 net. F. A. Davis Company, Philadelphia, 1931.

A very concise, well written book. It gives a good anatomical discussion upon which is based the symptomatology, diagnosis, and treatment of hemorrhoids and pruritus ani. The technique of injection treatment is described with illustrations, and case records are given. It is well worth adding to one's library. E. R. S.

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The Diagnosis and Treatment of Brain Tumors. By Ernest Sachs, A. B., M. D., Professor of clinical neurological surgery, Washington University School of Medicine, St. Louis. 224 illustrations, including ten in colors. Price $10.00. C. V. Mosby Company, St. Louis, 1931.

In this edition, Dr. Sachs has been eminently successful in giving to medical students, neuro-surgeons and those interested in the subject of brain tumors, a text-book of value. It is complete in every detail, well illustrated. Case histories are used throughout to advantage. The more recent developments in method of diagnosis of suspected brain tumors are adequately described and their relative value from the diagnostic side is well presented. The book is complete in every respect and can be highly recommended. J. L. G.

Medical and Surgical Year-Book. Physicians Hospital of Plattsburgh. Comprising Wednesday afternoon invitation lectures; papers of the cardiac round table; the first Beaumont lecture; collected papers by the staff: 1930. The William H. Miner Foundation, Plattsburgh, N. Y.

This volume comprises a series of conferences on cardiac hypertension and gastrointestinal diseases. The book is unique in that the subjects are presented as they are discussed at a round table meeting. The outstanding features of the presentation is the simplicity with which such difficult subjects as coronary diseases, etc., are given.

Some chapters deserve special comment as, for example, the treatment of pneumococcus pneumonias with serum by Dr. Bullawo, and especially instructive also is the chapter on heart failure without value lesions, as well as the unusual cases of cardiac thrombosis.

For the general practitioner, in fact, for any physician this is an entertaining and instructive compilation of papers. F. D. M.

The Physician of the Dance of Death. An historical study of the evolution of the dance of death mythus in art. By Aldred Scott Warthin, Ph. D., M. D., LL. D., professor of pathology and director of the Pathological Laboratories of the University of Michigan, Ann Harbor, 142 pages, 92 illustrations. Price $7.50. Paul B. Hoeber, Inc., New York, New York.

This well illustrated monograph on "man's changing psychological reactions to the concept of Death" during the past six centuries was inspired by a print of Albrecht Durer's "Ritter, Tod und Teufel," Knight, Death and Devil, which was purchased by the author when a medical student in 1893 and which formed the beginning of a collection of representations of Death in art, the choicest of which are here reproduced from the standpoint of Death and the Physician. The contents of the monograph embrace:

The period of the great wall paintings.

The pre-Holbein manuscripts, block books and incunabula.

Holbein, the great Dance of Death of the renaissance.

The imitatus of Holbein. The Rococo Period.

The period of caricature.

The modern Dance of Death.

The author points out that when the motive of the Dance of Death emerged six centuries ago death was thought of only in its horrible and gruesome aspects; there was no conception of death as a release from suffering or as a rest for the weary, while today the fear of death has in large part been lost and it is met with resignation or bravery or with cynical indifference. Modern representations of the Dance of Death lack the emotional richness necessary for art. In typical representations of the Dance of Death, members of all ranks of society are shown claimed by personified death, those of highest rank coming at the head of the procession. In one painting at Basel ascribed to 1450 thirty-nine social ranks are represented. The physician is number sixteen, which Warthin states is a higher rank than that shown in earlier paintings. The illustrations are of special interest from the point of view of dress and manners of various periods. The best caricatures reproduced are those of England of a century ago while the only modern artist whose art may be mentioned as being truly great as Holbein's was great is, according to the author, Alfred Rethel. After the period of caricature of the early 19th century the physician "steps out of the picture" in the "Dance of Death." This monograph may be recommended as interesting and well illustrated. Unfortunately, since the publication of the book, Death has taken its author by the hand. C. R. B.

Nutrition and Diet in Health and Disease. By James S. McLester, M. D., professor of medicine at the University of Alabama, Birmingham. Second edition, revised and reset. Octavo of 891 pages. Price cloth $8.50 net. W. B. Saunders Company, Philadelphia, and London, 1931.

This book serves as a fairly condensed summary of the current knowledge of nutrition, biochemistry, metabolism and dietetics. It is not an attempt to be thoroughly critical in evaluation of the contrasting points of view, but there is usually some evidence as to which alternative opinion or course of therapy the author approves. The references to the original literature are not encyclopedic but they do lead to authoritative data when that is desired. As a text for study of the fields covered this book should be valuable to beginners in dietetics, to medical students, and to physicians who have not kept abreast of the detailed publications in journal literature.

The practical aspects of the book in preparing menus and dietary regimes are pleasing. Much information is tabulated. The volume is a useful, ready reference book in hospital and office practice of clinical dietotherapy. It is one of the two best texts for the use of students in this field, and, due to its recent publication in thoroughly revised form,

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The Criminal, the Judge, and the Public: A Psychological Analysis. By Franz Alexander, M. D., and Hugo Staub. New York: The Macmillan Co. 1931. 238 pages. Translated from the German. Price $2.50.

In this interesting book the authors, (one a psycho-analyst, the other a judge), are presenting a new approach to the study of the criminal. It is their contention that the time is at hand for a complete revision of the present system of justice, which "is not supported by any moral effective forces and has nothing to offer but a mere matter-of-fact structure, poor in content and with outlived institutions." Further indictments are that the sense of justice has been too easily satisfied, judgments are rendered on the basis of purely objective criteria and there is little or no evaluation of the individual case.

In discussing the role of psychology in the understanding of the criminal, it is brought out that every criminal act is determined by many motives, the majority of which remain buried in the unconscious of the criminal. Thus they declare that psychoanalysis, with its special methods, can lead to a complete understanding of the criminal and his acts and add that the present day psychiatric expert is not equipped to deal adequately with criminal problems. They then take up the genesis of criminal behavior from a psychoanalytical viewpoint, describing first the gradual process of repression and inhibition which makes for socially acceptable conduct. They refer to the social part of the personality as the Super-Ego which acts as the censor of the Ego and prevents the instinctual impulses from expressing themselves unsocially. It is shown that, after all, the psychoneurotic and the criminal are somewhat closely related, psychologically, but the neurotic undergoes a self-inflicted punishment while the criminal directs his actions against the outside world. Criminals are classified into three large groups, (1) The neurotic criminal (psychological etiology), (2) The normal criminal (sociological etiology), and (3) The criminal whose conduct is due to some organic pathology (biological etiology).

The neurotic criminal is then discussed and the psychoanalytical conception of the neuroses cited to show how the demand for satisfaction and self-punishment in the neurotic parallels the criminal act and punishment in the offender; in other words, "The criminal and the law, taken together, perform the same task together as the neurotic does alone." Then, discussing the problem of responsibility, the authors state that free will is equivalent only to conscious motives found in the Ego; that any given act involves three dynamic psychological systems, —the Ego, Super-Ego, and the Id. They maintain that after an offender has been treated psychoanalytically, only then can he assume responsibility for his actions, for not until then is he able to bring himself into control of his unconscious. Thus the medicolegal expert who testifies in our courts today, they claim, is able to do little more than make a diagnosis. In discussing the part played by the Ego in crime, the importance of obtaining an understanding of the mechanisms of dreams is emphasized. They state that "while the dream expresses the unconscious criminality of man, the daydream demonstrates his actual criminal propensities." They then devote some attention to the general mechanisms of criminality,—projection, rationalization, self-punishment compulsion, etc. The neurotic criminal is described as being the one who comes into conflict with the law through acting out his unconscious drives or is driven by the impulse to be punished. He is a sick individual who suffers from a neuroses without symptoms, the latter being replaced by irrational behavior. Such cases can be reached only by psychoanalysis, but are quite amenable to psychoanalytic therapy. They say, "To punish such individuals is psychologically meaningless and sociologically harmful", for unconsciously they feel the need of punishment and welcome the severity of the law. In treating criminal perversions, the authors point out that these are not influenced by the responsible part of the individual's personality; that the Edipus complex plays the central role in their development and that the pervert is the victim of false methods of bringing up. A greater tolerance of these individuals is urged.

Several interesting cases are reviewed at length, with a psychoanalytical interpretation of the criminal acts involved. In the concluding chapter it is suggested that all forms of punishment for the neurotic criminal be abolished and that he be turned over to a psychoanalyst for treatment; that punishment be applied only to the normal criminal. Rational treatment is made difficult because of the public demand for atonement and retaliation. The psychology of punishment is gone into in some detail.

This book will naturally be read with interest by the psychiatrist and perhaps also the jurist, although the latter may not be sympathetic with such an extreme position as that taken by the authors. One is convinced that there is a great deal that might be contributed by psychoanalytic methods and it is hoped that some demonstrations can be made in one or more of our American courts. The authors quite ignore the marked advance that dynamic psychiatry has made in its relationship to criminal procedure, since they make several statements to the effect that the medico-legal expert of today is not equipped to render much service to the judge. This declaration, along with the proposal that the judge himself should be trained to be the expert in the understanding of human behavior, may not be so well received. R. E. B.

The International Medical Annual. A Year Book of Treatment and Practitioner's Index. Editors: Carey F. Coombs, M. D., F. R. C. P. and A. Rendle

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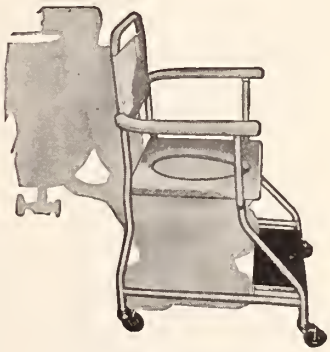

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The Medical Annual is a review of the year's work in the treatment of disease throughout the world, compiled by twenty-five of the most able British physicians. Its function is to furnish a digest of the world's medical literature, critically considered and reduced to a small bulk, by these competent authorities.

The writers make note of new or improved methods of diagnosis and treatment that promise to be useful wherever they may be published. As a rule, they include but few articles on pathology or details of animal experimentation. The object of the book is to furnish to the busy practitioner, in the smallest possible space, what seems to be the outstanding advances in medicine during the year. Its excellent alphabetical arrangement of subjects, together with the adequate reference paragraphs to source material, do much to make it an extremely practical and valuable book for any physician's library.

Certain subjects in the present volume are of particular interest. The paragraphs on Dental Caries and Dental Infections is excellently edited. The author notes "As a result of a recent visit to America in which I had an opportunity of studying the science and practice of dentistry in many different places, I am of the opinion that the Americans as a nation are tackling the problem of dental diseases in children more efficiently than the European countries, including Britain."

Of increasing interest to practitioners everywhere, is the recognition of Undulant Fever due to Brucella abortus, the authors in most instances feel that the cause can be directly traced to the consumption of unpasteurized milk derived from an infected cow.

The continued interest that is being manifested all over the world in asthma, and allergic conditions in general, is well reviewed and of real interest.

The increasing interest which the medical profession must, of necessity, take in industrial accident cases, makes the paragraphs on Traumatic Neurosis of exceeding interest.

Insulin and its uses in fields other than that of the treatment of diabetes may be reviewed with value to any practitioner of medicine.

The review of conditions arising in general abdominal surgery includes many suggestions of interest. A report on over 2600 cases of gastro-enterostomy showing a 90% greatly relieved or cured result, is of interest. A suggested operation to divert the bile into the stomach in cases of cholecystitis, is also worthy of attention.

It is of exceeding interest to note that in Germany, 15,000 women die annually as a consequence of criminal abortion, and many more suffer as a result of anti-conception methods.

Exceptionally fine work has been done throughout the world on new methods of inducing anesthesia and particular interest is being focused on the spinal method of producing this result.

The frequency with which lung abscess develops following tonsillectomy in America, and its relative rarity in Europe, may be due to the difference in posture in tonsil operations is worthy of note.

Finally, the fact that the past year has produced no new antidote for any infection is of interest. R. C. B.

Diabetes. Its treatment by insulin and diet. A handbook for the patient. By Orlando H. Petty, A. M., M. D., F. A. C. P. Professor of diseases of metabolism, Graduate School of Medicine, University of Pennsylvania; physician in charge of departments of diseases of metabolism, Hospitals of the graduate school of medicine, University of Pennsylvania, and Philadelphia General Hospital; consultant in diseases of nutrition and metabolism, Shriners' Hospitals for Crippled Children, Philadelphia Unit. With illustrations and tables. Fifth revised and enlarged edition. Price $2.00 net. F. A. Davis Company, Philadelphia.

This volume, like its preceding editions, is the basis for the author's management of diabetic patients. It makes no distinctive contribution other than a detailed series of diets for Jewish patients who desire orthodox foods. The subject matter is in part beyond the necessary or even desirable material about which any clinician cares to instruct patients. E. L. S.

Practical Dietetics for Adults and Children in Health and Disease. By Sanford Blum, A. B., M. S., M. D. Head of department of pediatrics, and director of the research laboratory, San Francisco Polyclinic and Postgraduate school. Fourth edition revised and enlarged. Price $4.00 net. F. A. Davis Company, Philadelphia, 1931.

This book endeavors to be extremely practical by giving many sample menus for cases of illness, in which the age, sex, occupation, and social standing of the patient are specified in addition to the medical diagnosis. Consequently the book savors of the day in the practice of medicine when highly empirical prescriptions were taught students by the physician who had seen patients improve with the use of his favorite mixture. There is in the book no systematic attempt to explain the principles of normal dietetics or of dietotherapy in general. If specific conditions are examined it will be found that this volume is far from being abreast of the well demonstrated advances in diet treatment of such patients as the diabetic, the obese, and the pernicious anemic. There is so little to recommend this book that it need not be considered by the dietitian, student, or physician. E. L. S.

Food Allergy. Its Manifestations, diagnosis and treatment with a general discussion of bronchial asthma. By Albert H. Rowe, M. S., M. D. Lecturer in medicine in the University of California Medical School, San Francisco; chief of the clinic for allergic diseases of the Alameda County Health Center, Oakland; consultant in allergic and meta-

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bolic diseases, Highland Hospital; president of the Association for the Study of Allergy, 1927–1928. Price $5.00 net. Lea & Febiger, Philadelphia, 1931.

That one man's food is another man's poison is an ancient proverb. That minute traces of common foods may have far reaching toxic effects in susceptible individuals is a recent subject of scientific investigation. Food allergy is of interest both to general practitioners and to specialists in many fields of medicine. The volume under review is written by an internist specializing in the field of allergic diseases, and gives an excellent summary of the present knowledge of a subject perhaps the more interesting because of its many mysteries. The importance of testing food allergy by trial diets as well as by skin reactions is emphasized. Basal "elimination diets" are recommended consisting of food substances to which patients are seldom sensitive and which are ample for health. Directions are given for altering these diets to suit the needs of individual patients. They form an essential part of the therapy recommended. The relations of food allergy to allied conditions such as bronchial asthma, hay fever, migraine and allergic disturbances of the skin are discussed and a concise summary of the chief literature is given. It is a worth while book. C. R. B.

Treatment of Injury by General Practitioner. By Clay Ray Murray, M. D., Ass't. Prof. of Surgery College of Physicians and Surgeons.

The purpose of this book is very well stated by its title.

It tells what to do and how to do it in a very acceptable fashion. Very little space is devoted to the subject of diagnosis, it being taken for granted that in most cases it is self evident.

It can be recommended as a practical book containing much useful information to any one to whom injured patients may come. R. E. B.

White House Conference, 1930. Addresses and abstracts of committee reports. White House Conference on Child Health and Protection called by President Hoover. The Century Co., New York. 1931.

The Conference, the proceedings of which are here summarized, assembled in Washington Nov. 19–22, 1930. The attendance is estimated at 3,000. The call for the Conference was issued by President Hoover in July, 1929, "To study the present stature of the health and well-being of the children of the United States and its possessions; to report what is being done and how to do it." The first conference of this character was called by President Roosevelt with special reference to the dependent child and resulted in the establishment of the Children's Bureau of the U. S. Department of Labor. The second conference was called by President Wilson at the request of this Bureau in 1919. Problems relating to maternity and to childhood were discussed with special reference to state and national legislation. The Sheppard-Towner Act followed. The third conference not only included the subject embraced in the two former conferences but was enlarged to cover the subject of childhood from a broad scientific and social standpoint. Preliminary to the main conference numerous committees of experts were appointed to study various phases of the subject under the following chief subdivisions: medical service, public health and administration, education and training, and the handicapped. Over 1,200 individuals were included in these various committees and numerous sub-committee meetings have been held. The main conference, the work of which is summarized to the present volume, was followed in February, 1931, by a meeting of the section on Medical Service. The proceedings of this session were reported in a special supplement to the United States Daily on April 6, 1931. It is stated that the work of the various committees when finally published in full will fill thirty or more large volumes and will give a more complete view of the present knowledge of childhood than has hitherto been available as a basis for private and public dealing with the problems presented. A special committee has been appointed to follow up the work of the conference. The present volume is of interest to every practitioner of medicine from the point of view of some of the broader problems presented. C. R. B.

The Infant Welfare Movement in the Eighteenth Century. By Ernest Caulfield with a forword by George Frederick Still. Paul B. Hoeber, 1931. 203 pages, 8 illustrations. Price $2.00.

Dr. Caulfield presents in this small book much interesting information collected from contemporary sources concerning child-life, child welfare and diseases of children during the eighteenth century in England. The modern active child welfare movement, which has recently been given renewed vigor in this country by the White House Conference, had its beginnings in the eighteenth century although at that time in general "children were regarded as a necessary evil and, except in time of alarming and grave illness, were little considered. Evidence of neglect, cruelty, and infanticide are so abundant that one is forced to believe that at times children were not even considered necessary." It is stated that in the two decades 1730–1750, 75 percent of all children christened died before the age of five. "The children of the wealthy were neglected because of fashion, the children of the poor were neglected because of poverty." The beginnings of the awakening of public conscience to the welfare of infants and children and the leaders of this movement in England are here clearly pictured. C. R. B.

Eye, Ear, Nose and Throat for Nurses. By Jay G. Roberts, Ph. G., M. D., F. A. C. S., Pomona, California. Licentiate, American Board Otolaryngology; chief of staff, Eye, Ear, Nose and Throat, Los Angeles County Health Center; member staff, Pomona Valley Community Hospital; Author of "Bacteriology and Pathology for Nurses." Illus-

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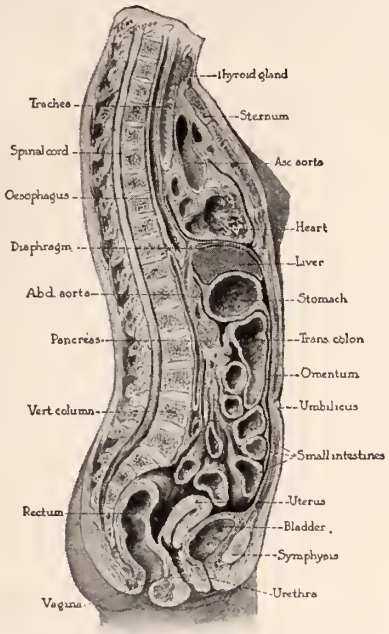

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trated with 102 half-tone and line engravings. Price $2.25 net. F. A. Davis Company, Philadelphia, 1931.

This appears to be a fairly satisfactory text book for nurses. The surgical technique described is excellent. M. O. E.

Chemistry for Nurses. By Harry C. Biddle, A.M. 322 pages. F. A. Davis Company, Philadelphia, 1931. $2.75.

This book is prepared by an instructor of nurses with considerable experience. The volume is well bound, well printed, and contains 74 illustrations, many of which are well chosen. The plan of the book includes questions at the beginning of the chapter which arouse interest in certain practical applications of the chemical principles to be discussed. There are at the end of a chapter review questions to assist in consolidating the information. The tabulated information and the definitions of terms are available for easy reference.

This book, however, seems to represent an entirely too ambitious program of chemical instruction for use with students in a course in nursing. The author states that it is designed for a 45 hour course. It would appear that it would be a very useful text for the course of instruction with two or three times as much laboratory and discussion time. This is too often characteristic of instruction in a special field provided by one who is not trained in the field in which his students will work. The program of topics assigned could not lead to careful reading, and therefore, appears entirely useless.

It is regrettable that the book contains a number of inaccuracies. Definitions and discussions of such phenomena as osmosis, isotonic solutions, absorption, cause of scurvy, the oxidation of organic acids in the body, are treated inaccurately. These errors might well have been detected and corrected if the volume had been reviewed in advance of publication by a man of experience in bio-chemistry and nutrition. As a consequence, of these difficulties it might be said that this book would be fertile in its suggestions to a teacher for such a course, although it is hardly to be recommended as a text for nurses. E. L. S.

Practical X-Ray Treatment. By Arthur W. Erskine. Bruce Publishing Company. 1931. 116 pages, 28 illustrations and 12 charts. Price $3.50.

This book gives a concise account of the therapeutic methods employed by one of America's foremost radiologists. It should be of interest to experts in the field for comparing their own methods with those employed by the author. It should prove of practical value to beginners in x-ray therapy because it gives the results of matured experience. It should serve as a warning to those contemplating entering this field without adequate preparation because it reveals the extensive training necessary for safe and useful x-ray therapy. As the author states, "Over-dosage may result in permanent injury to the patient but under-dosage, always staying on the safe side and never doing any harm, may take away his only chance for life." C. R. B.

Textbook of Histology. For medical and dental students. By Eugene C. Piette, M. D., pathologist and director of the Laboratory of the West Suburban Hospital, Oak Park, Illinois. Consultant pathologist of the Chicago State Hospital, Chicago. With 277 illustrations, some in color. Price $4.50 net. F. A. Davis Company, Philadelphia, 1931.

The author of this text has accomplished what he set out to do; first to write a short text of histology and organology, and second to include enough physiology to relate anatomical structures to their function. It is written in an interesting style. It is not extensively sub-topiced but all important terms are in heavy type. It is richly illustrated with clear cut, partly semi-diagrammatic drawings. The text is brought up to date by the consideration of recent literatures both European as well as American giving the names of the investigator. Tissues are given 178 pages, Organs and Systems 200 pages, and the Nervous System 88 pages. T. H. B.

MEDICAL LIBRARY SERVICE

If you are interested in the historical aspect of work in obstetrics and gynecology, you will find an exhibit in the Memorial Room of the Medical School.

First there are plates from the "Rosegarten" of Eucharius Roesslin, produced in 1513 at Worms. Though it is a compilation from Soranus of Ephesus, it was still the only textbook in the field after a lapse of fourteen centuries.

Next is the treatise of Francois Mauriceau (1637–1709) of Paris on "Diseases of Pregnant Women", illustrated with copper plates. He not only gave a good account of normal labor and of version, but was the first to refer to tubal pregnancy, and epidemic puerperal fever.

Following Mauriceau, there are the works of other early French, and of English obstetricians, including chronologically, André Levret, John Burns, Mmme. LaChappelle, John Armstrong, and John Francis. The writings of these workers cover the period of 1766 to 1829, as shown in the cases.

The popular Sir Astley Cooper's (1768–1841) "Anatomy of the Breast" follows in the display. Cooper had a passion for dissection, and paid large fees to the body-snatchers. It is said of him that every day of his life he dissected, even while traveling. Cooper was one of the first surgical teachers to substitute practical demonstrations over an actual case for the old theory-method of teaching.

William Smellie (1697–1763) of London, introduced the steel lock forceps in 1744, and the curved and double-curved forceps in 1751 to 1753. He

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wrote a set of "Anatomical Tables" on obstetrics in 1754, and these tables are also on view.

The greatest work of William Hunter of Glasgow is his atlas of the pregnant uterus, published in 1774, and representing the work of thirty years. His work encouraged the use of other means than that of forceps, and his discoveries form the basis of our modern knowledge of placental anatomy.

The works of early American obstetricians and gynecologists come next. They cover the period of 1819 to 1866, and they are: (listed chronologically by author) Samuel Bard, William P. Dewees, Charles Meigs, and Hugh L. Hodge.

Oliver Wendell Holmes (1809–1894), witty and literary professor of anatomy at the Harvard Medical School, contributed to this branch of science, a work on puerperal fever. His "Medical Essays" are on display, and conclude the modern American period as exhibited. J. B. P.

PRESS SERVICE

(Continued from page 585)

THE FIRST TEETH

Madison, Wis., June 17—It is a great mistake for a mother to allow a child's first set of teeth to decay just because they are baby teeth. Baby teeth decay and have abscesses which are as harmful as the decay and abscesses in the mouth of grownups, and a child's health is often impaired by failure to look after the babyhood teeth.

The Educational Committee of the State Medical Society in a bulletin issued today declares that, until recently, the importance of caring for baby teeth was little understood. Now it is realized, declares the bulletin, that many of the ills and suffering of children may be traced directly to a lack of mouth hygiene. It is estimated by federal authorities that sixty per cent of all children in the United States under the age of fourteen have one or more defective teeth.

"Children should be taken to a dentist when they are three years old or as soon as all the baby teeth are in place, then once or twice a year in order that any decayed baby teeth may be filled," declares the bulletin.

"There is another important reason why young children should have their teeth attended to regularly by a dentist. If the last baby tooth to erupt is allowed to decay and has to be extracted the big six year molar back of it may tip forward. It may never stand up straight and all the other teeth in front of it may therefore be crooked and out of place. Moreover, lack of care of the baby teeth often cause crowded, ugly looking sets of permanent teeth. Such irregular teeth decay more rapidly, are harder to keep clean and as grinders for food they give poor service.

"Each properly formed six year molar has deep projections or cusps; the cusps of the upper tooth fit into the grooves of the lower, so that a perfect interlocking of the teeth takes place as the jaws come together. Nature has done this in order that food may be ground and crushed when it is chewed. But, if one six year molar comes in forward of its proper position because some of the temporary teeth were lost too soon, these cusps and grooves will not properly interlock. Instead, the cusps might strike against each other, thus throwing that whole side of the mouth out of alignment, and often altering the contour of the face unfavorably.

"Watch the six year molar; the little crevices on the grinding surfaces should be kept as clean as possible all the time. If they start to decay, which they are very apt to do, have the cavities filled without delay.

"Most of the large cities have school inspection in order to find physical and dental defects. Many communities have school dental clinics where children's teeth are cleaned and fillings inserted. In this way the millions of children badly in need of dental care receive the necessary attention. Every community should have such facilities not only to educate the parents but also to teach the children the importance of mouth hygiene and especially to aid those who unfortunately can not afford dental service."

HIGH BLOOD PRESSURE

Madison, Wis., June 24.—High blood pressure is the real cause of many of the deaths due to a "stroke." In the beginning the disease is not so dangerous but it becomes a menace to health through inattention. High blood pressure is usually the cause for those rather common reports of death from a stroke of apoplexy.

The Educational Committee of the State Medical Society in its weekly bulletin declares that prompt attention can keep people from the dangers of high blood pressure.

"In reality the condition is not so much a disease of the heart as it is an exhausted state of the organ brought on by the excessive work necessary to maintain the circulation in the presence of increased pressure in the arteries," declares the bulletin. "High blood pressure may bring on a hardened condition of the arteries which weakens them so that under a particularly hard stress a small vessel in the brain may give way and the individual has what is known as an apoplectic stroke.

"If the kidneys are not already diseased and the initial cause of the high blood pressure, they also may become deranged leading eventually to a fatal outcome by Bright's Disease. High blood pressure with normal kidneys may be present for many years but high blood pressure associated with kidney disease is a serious matter.

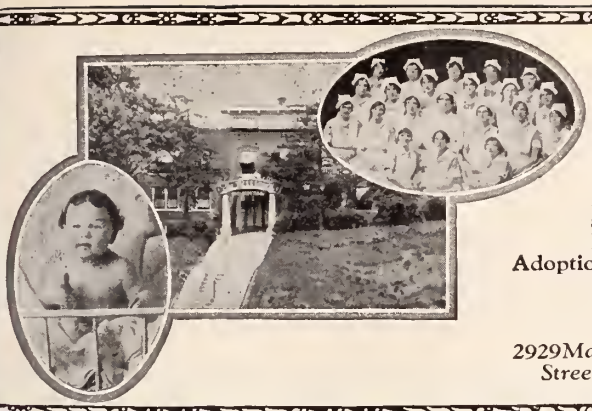
"Thus, high blood pressure, unrelieved, leads after years to one of three disastrous terminations, an exhausted heart, an apoplectic stroke, or death from chronic kidney disease.

"No one knows just what is the cause of high blood pressure. Many causes have been suggested such as excessive meat eating, excessive coffee, tea, or alcoholics, infected teeth and tonsils, constipation, heart disease, overweight, and a host of others but it is doubtful if any of these have anything to do with the initial establishment of high blood pressure.

"There is a normal increase in blood pressure with an increase of age. One often hears that the blood pressure should be one hundred plus one's age—this is a rough estimate at best and does not generally hold after thirty-five to forty years.

"A normal child never has high blood pressure. Elimination of his waste products is thoroughly maintained by the kidneys, assisted by the skin glands and deep respirations induced by games and other body exercise. By thirty most people begin to slow down somewhat and by forty the average person has become more or less sedentary with marked slowing of body activity and addition of weight. This is fairly definite evidence that he eats more than he burns up by exercise.

"The surest way to forestall the advent of high blood pressure is to take stock yearly of the state of the cardio-vascular system by having a thorough physical examination. If you are told after your annual examination that you blood pressure is a little high, do not spend your nights in worry. Medical science has found safe ways of bringing it down, and by following your physician's directions you can live a long, happy and useful life."



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INSULIN COURSE

(Continued from page 584)

onstration of dietary work by Miss Lenore Healey, special dietitian at the Wisconsin General Hospital. In her work she was assisted in each city by one or more of the local hospital dietitians. The cooperation of the hospitals made possible the use of actual foods and the preparation of the trays just as for the use of patients.

Dr. Wilder gave especial attention to the problems of the diet for the growing child. Since diabetes is no longer incompatible with normal length of life, the child, and the adult patient as well, must be taught methods of eating and of hygiene which are adequate for his entire life span. It was of interest that Dr. Wilder advised the use of insulin in all juvenile diabetes, for the sake of avoiding sudden changes in routine even though some children may be managed temporarily without insulin. He also discussed the improved outlook in pregnancy which occurs in diabetic women.

Dr. McKittrick devoted his attention to the problems of surgery in the patient with diabetes. His presentation of the indications for surgery made clear the conditions under which operative treatment can be undertaken without added risk because of the metabolic difficulty. The illustration of the types of lesions in the feet by photographs from his own experience enabled him to point out which cases require the varying types of amputations. The surgical principles involved were stated simply enough so that they will serve as a guide to surgeons with less experience who are increasingly confronted with the necessity for surgical treatment of diabetic individuals.

Dr. Sevringhaus pointed out the few essential diagnostic procedures including the indispensable use of blood sugar determinations to establish the presence of true diabetes. In outlining the treatment of coma, he presented the vitally important measures for the relief of this emergency, but without the use of equipment other than that found now in every small hospital. The scheme of diets for use in the usual maintenance of diabetics, as well as the diets for obese patients and the liquid diets for emergencies, was made available to every doctor present. For this purpose each man who registered was given a copy of the "Guide for Diabetic Patients" published by the Wisconsin General Hospital. This book, just published in its sixth edition, represents the experience of Dr. Sevringhaus and his associates in the treatment of diabetes since the introduction of insulin in 1922. The new edition has been enlarged by the inclusion of a section for the exclusive use of physicians. This section includes in condensed form much of the information which was presented by Dr. McKittrick and Dr. Wilder, as a consequence of which the book served the place of lecture notes.

In each city a lecture for the lay public was given in the evening by Dr. Sevringhaus. He endeavored to show patients how unsafe it is for them to attempt to carry on the treatment of either obesity or of diabetes without the supervision and assistance of the family physician. At the conclusion of these lectures questions were answered and it was evident that there is still much room for a better education of the public in the need for careful and continuous treatment of diabetes. About 1000 people were reached in these lectures. Of even greater interest is the fact that the 310 doctors who attended the course came from 135 cities and towns. The significant feature of this series of institutes is that the modern methods for the treatment of diabetic patients have been made readily available to the doctors in such a large portion of Wisconsin just 10 years from the time that the work of Banting and Best was begun in Toronto, leading to the discovery of insulin. It is the hope of those who have promoted these courses that the diabetic death rate will show a more definite decrease in Wisconsin than has already been seen, and that the plane of efficiency of Wisconsin's many diabetics will be greatly improved.

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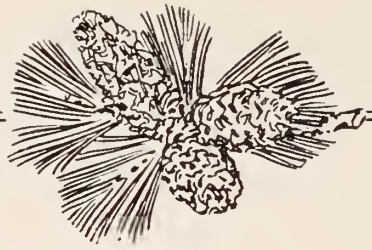

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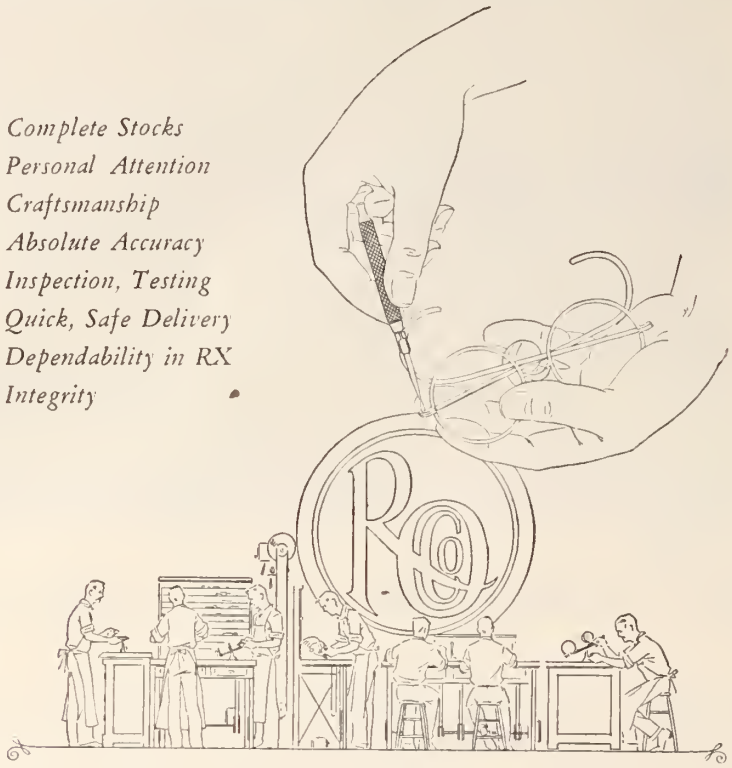

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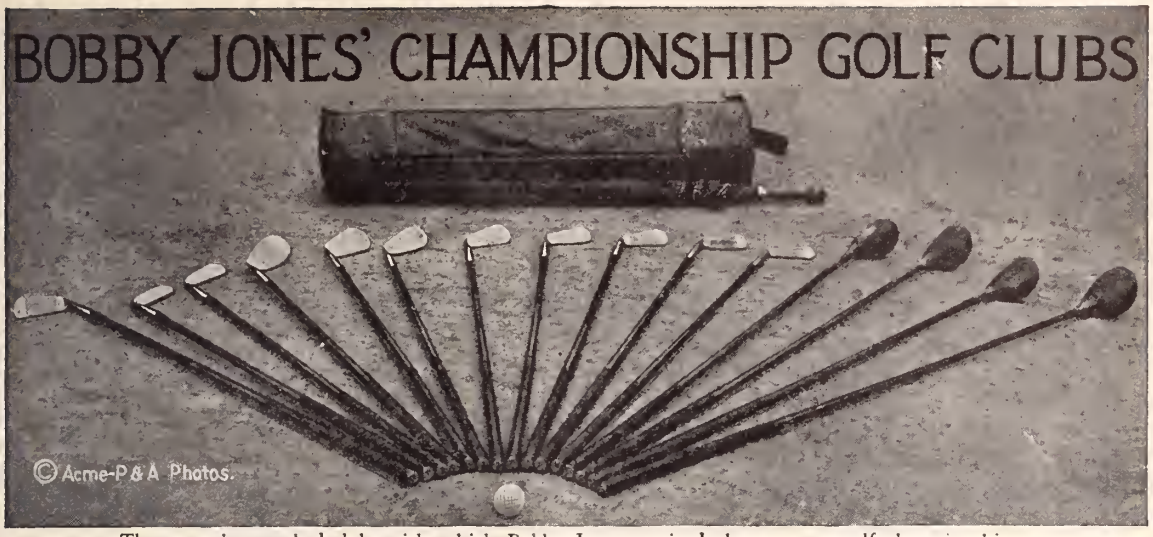

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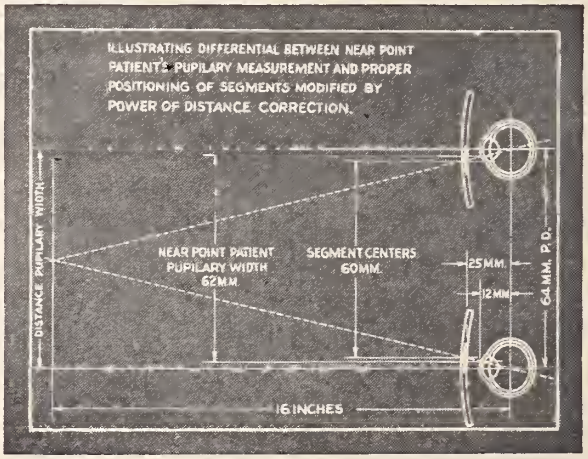

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The Wisconsin Medical Journal

Volume XXX AUGUST, 1931 No. 8

Medical Aspects of Jaundice*

By RAY C. BLANKINSHIP, M. D.
Madison

In order to approach this subject properly, permit me to state first the well known fact that jaundice is only a sign or symptom and not, of course, in itself a disease. With this in mind, the internist looks at jaundice as a direct challenge and the problem is primarily, often times solely, one of diagnosis.

In this communication I shall, therefore, discuss briefly some of the more popular laboratory tests and stress only those factors which, taken from the clinical picture as a whole, lead, after thorough digestion and understanding, towards ultimate accuracy in our analysis and deductions. On paper with the history, physical examination, and laboratory data before us, together with what is claimed each test will tell, nothing could seem more simple than to classify any given case and designate the underlying cause. Unfortunately, however, in dealing with jaundice just as in dealing with a pain or a cough, we often find, after all the clinical facts are assembled, the parts, particularly if we place too much emphasis upon methods of precision, will not fit together so as to make a rational diagnosis.

BILIRUBIN AND JAUNDICE

Previous to the time of van den Bergh's (1) report on his method of estimating the bilirubin content of the blood serum, attention had been focused largely upon the skin manifestations in jaundice to the neglect of what might be going on in the blood stream. We have since found that there is much to be learned about diagnosis, prognosis and treatment through studies based on the amount of bilirubin in the blood serum, the urine, and the stools. Van den Bergh estimated the normal serum bilirubin to range between one part in a million to one in 400,000 or thereabouts, and his unit of one equals a concentration of one to 200,000. It has been found, furthermore, that this concentration must reach about one in 50,000 (four units) before bile begins to appear in the urine and before there is sufficient concentration of pigment to stain the skin. Such bilirubinemia without visible icterus has, as you know, been designated as latent jaundice.

For the purpose of review it might be stated that the physiology of bile pigment and the mechanism of jaundice in brief is as follows: Hemoglobin (there is no other known source of bile pigment) is broken up by the phagocytic cells in the body (notably in the spleen, liver and bone marrow) into bilirubin and a colorless iron containing residue. Both re-enter the blood stream. The bilirubin is normally taken up by the hepatic epithelial cells and excreted into the bile canaliculi and thence it passes along with and a part of whole bile through the biliary ducts into the duodenum. Bilirubin itself it is said can be absorbed from the intestines back into the blood stream (2), but it is normally partially excreted in the stool and partially reduced in the intestines to urobilogen. Some of the urobilogen so formed passes out in the stool, a minute amount appears in the urine and the remainder is reabsorbed to find its way back to the liver.

There are actually only two ways in which jaundice may be brought about:

1. By something which obstructs the normal onward flow of the bile (regurgitation jaundice) anywhere from the hepatic epithelial cells lining the bile canaliculi (necrosis) to the papilla of vater (stones, etc.) and
2. Excessive destruction of red blood cells with resultant bilirubinemia, plus impaired function of the liver cells (retention jaundice).

* Presented before West Virginia State Medical Association, May, 1931. Published by permission of West Virginia State Medical Journal.

Rich's Classification

TABLE I

I. RETENTION JAUNDICE Laboratory tests: Blood — indirect v. d. Bergh Stools + urobilin Urine + urobilin Cause — Overproduction of bilirubin + subnormal liver function caused by	A. Anoxaemia, caused by	1. Anaemia	Pernicious anaemia Haemolytic jaundice Sickle-cell anaemia Paroxysmal haemoglobinuria Mismatched transfusion Phenylhydrazine poisoning
		2. Chronic passive congestion	Cardiac decompensation (especially with pulmonary infarction)
	B. Febrile disease, associated with anoxaemia resulting from	1. Anaemia	Haemolytic septicaemias Malaria Black-water fever
		2. Pulmonary consolidation	Lobar pneumonia
	C. Immaturity of liver cells in	Newborn	Icterus neonatorum
	D. Undetermined		Hanot's cirrhosis

TABLE II

II. REGURGITATION JAUNDICE Laboratory tests: Blood — direct v. d. Bergh Stools — decreased urobilin Urine + bilirubin and bile salts Cause: Rupture of canaliculi, caused by	A. Necrosis of liver cells caused by	1. Toxic agents	a. Chemical	Chloroform Carbon Tetrachloride Phosphorus Salvarsan etc.
			b. Vegetable	Mushroom poisoning Yellow fever
			c. Bacterial	Congenital syphilis Weil's disease
			Undetermined	'Idiopathic' acute yellow athophy Laennec's cirrhosis
		2. Severe degrees of A and B, Table I		
	B. Obstruction of bile ducts caused by	1. Plugging	a. Calculi	Cholelithiasis Pancreatic calculi
			b. Inflammatory exudate	Cholangeitis
			c. Parasites	Fasciola hepatica Ascaris etc.
			d. Neoplasms	Tumors of bile ducts
		2. Stricture	a. Scarring	Chronic cholangeitis Syphilitic cirrhosis
			b. Malformations	Congenital stenosis or atresia of ducts
			c. Neoplasms	Primary or secondary tumors involving bile ducts
			a. Inflammatory masses in liver	Abscess Gumma Tubercle Hodgkin's disease
			b. Parasitic masses	Echinococcus cyst

	3. Pressure	c. Vascular tumors	Aneurysm of hepatic artery
		d. Inflammatory tissue outside liver	Peritoneal adhesions
		e. Neoplasms	Tumors of pancreas, gall-bladder, liver, etc.
		f. Enlarged hepatic lymph nodes	Tumor metastases Hodgkin's disease Tuberculosis
C. Undetermined			Catarrhal jaundice

Thus it is seen that we now have a fairly accurate means of visualizing the changes which may take place in the physiology of bilirubin incident to the development of jaundice.

CLASSIFICATION

In the classification of jaundice one finds a widening field from which to choose. Originally it was obstructive and nonobstructive. Van den Bergh (3) tried mechanical and dynamic-terms used synonomously with obstructive and nonobstructive. McNee (4) suggests a subdivision into:

A. Obstructive
B. Hemolytic, and
C. Toxic and infective.

Recently Rich (5) has offered a most comprehensive grouping which seems to be a long step in the right direction. His classification is reproduced here without change.

A study of this classification shows with reasonable accuracy into which group a given case might be expected to fall and it also indicates the limitations of the laboratory as well as just how much aid may be expected therefrom. Personally, I feel there is need to get away from too much classification and get down to diagnosis. It is apparent, however, that in doing this such a grouping lends definite assistance in keeping constantly before us the numerous possible causes with which we must be familiar.

SPECIAL LABORATORY TEST

A detailed discussion here of the various methods of precision does not seem warranted. I do wish, however, to point out certain facts pertaining to the more important of these tests and to discuss their interpretation and relative value.

Urobilogen is formed from bilirubin by a process of decomposition and this change takes place largely, if not entirely, in the intestinal tract (6). Urobilin as such does not occur in the freshly voided urine. It represents a further oxidation product of urobilogen and this change occurs most rapidly if the urine is allowed to stand in the light. If we must do with one test (and in most cases we can do without any), let us take the test for urobilogen in the urine as described by Wallace and Diamond (6). A positive test for urobilogen is normal in dilutions of 1 to 10. If, however, the test is positive in greater dilutions, it is an indication that the case in question does not have "obstructive jaundice", but belongs among those conditions listed in Table I (retention jaundice). On the other hand, in Table II (regurgitation jaundice) one finds only those disorders usually associated with bile, but no increase in urobilogen, in the urine. This test is of some definite value in differential diagnosis because if obstruction is present and complete there will be no urobilogen in the urine (because bilirubin is unable to reach the intestines.) On the other hand, in retention jaundice nothing stops the excessive flow of bilirubin into the duodenum and consequently there is an excess of urobilogen—which, assuming integrity of the kidneys, appears in the urine.

ICTERUS INDEX (7, 8, 9, 10, 11)

The icterus index is a simple colorimetric method of estimating the amount of yellow staining pigments in the blood serum. It is not specific for bilirubin and will show stain-

ing of the serum from other causes (for example, lutein and carotin). It is also subject to alterations by hemolysis or lipemic opalescence (12). However, for practical purposes it is the most convenient means now at our command for (1) measuring the gross amount of pigment in the blood serum, (2) following the course of jaundice whether under treatment or not, (3) differentiating diseases, notably pernicious anemia from malignancy. By and large, the icterus index, a much simpler test, has been found to parallel the Vandenbergh not accurately but with reasonable constancy. Anything above the reading of 7 to 8 indicates an excessive amount of circulating pigment.

VAN DEN BERGH

This test, as you all know, is a chemical test quantitatively measured by a colorimetric method. Its definite advantage over the icterus index, aside from what has been said above, is that the van den Bergh is specific for bilirubin. Two separate and distinct reactions (direct and indirect) with Ehrlich's diazo reagent are possible, although it is now believed that the bilirubin in both cases is the same, and that the difference between the direct and indirect reaction is due only to differences of the medium in which the pigment is contained. According to Barron (13), bile salts and cholesterin are especially potent in binding plasma, proteins, thereby preventing ready absorption of bilirubin. Snider and Reinhold (14) recently published data tending to prove that the direct or indirect reaction is merely a matter of concentration of bilirubin in the serum. They found normal blood serum changed from a negative van den Bergh to an indirect, then a diphasic and finally a direct reaction as increasing amounts of bilirubin were added to the serum. M'Gown (15) attributed an indirect van den Bergh in certain anemias to a low alkali reserve. Whatever the ultimate explanation of the direct or indirect reaction may be, it is clear according to Rich (5) that when plasma bilirubin gives a direct reaction it indicates that whole bile including bile salts and cholesterin has been regurgitated into the blood stream, whereas if the reaction is indirect it informs us that the bilirubin has not been regurgitated from the canaliculi but that it represents pigment which the liver has not yet been able to remove from the blood. Thus, broadly speaking, according to the old classification in the first case, we would be dealing with obstructive jaundice (regurgitation jaundice) and in the second case with hemolytic jaundice (retention jaundice). A diphasic reaction intermediate between direct and indirect would naturally result from the presence of both direct and indirect reacting bilirubin in the blood plasma. Such, for example, as that which occurs in the severe anemias, chemical poisoning, and at times catarrhal jaundice.

An excellent description of the technique of the van den Bergh reaction can be found in papers by McNee (4) and by Brochus and Shay (16). The clinical application of this test has probably contributed to many errors, but it has also done much to stimulate further work on the origin, nature, behavior and fate of bilirubin and consequently has enhanced our knowledge of jaundice. Its proper place in the differential diagnosis, however, has not yet clearly been defined.

FRAGILITY TEST

The resistance of the red blood cells to hypotonic salt solution has been determined in some clinics more or less routinely for a good many years, as another laboratory test which might yield evidence. Normally the red cells show beginning hemolysis in salt solution at a concentration of approximately .42 per cent which is complete in concentrations of about .3 per cent. In familial hemolytic jaundice the fragility of the cells is definitely increased with beginning hemolysis at a .6 per cent and complete at about .42 per cent. Just the opposite occurs in pernicious anemia where it is found that the cells are more resistant than normal, while in the so-called obstructive jaundice there is no change. The limitations of this test are immediately apparent. It aids in differentiating the familial hemolytic type from all other forms of jaundice.

DIAGNOSIS

While a clear understanding of the mechanism of jaundice, the commonly used labo-

ratory test and their rational interpretation does make for better efficiency in the application of our unaided faculties of analysis and reasoning, we *can* make a diagnosis in the great majority of cases without technical assistance. Being in the habit of committing myself, right or wrong, in every case before the laboratory reports are available, I have found that if this original impression is changed at all it is just as apt to be changed by virtue of some new fact established in the history as because of what is reported from the laboratory. Let me emphasize the fact that no one point in the evidence should ever be permitted to weigh too heavily in one direction or another. The important thing is to keep in mind the clinical picture as a whole and it is upon this that our diagnosis and treatment must finally be based. The balancing of all facts obtainable in each individual case with an acute consciousness at all times of the salient points in the history is most important. In some cases no laboratory aid is needed, the diagnosis being clear from the history alone. In others we may be called upon to use every tool in our workshop. In my own experience and observation, errors in diagnosis have occurred not through lack of knowledge but through failure to apply what we already know. Repeating this platitude is justifiable just as long as the need for repetition exists. We must learn to look at the urine and the stools and to assimilate important points in the history and physical.

I shall not attempt to do more here than to briefly discuss the more common types of jaundice. As indicated, the best approach to diagnosis is that which is made possible by clear understanding of pathogenesis and probable etiology.

ICTERUS NEONATORUM

If we begin with the newborn, we can safely say that, except in congenital anomalies, icterus neonatorum is a physiological jaundice present, though not always visible (a latent jaundice), in all newborn infants. It is due to a rapid hemolysis with the resultant bilirubinemia incident to readjustment in the blood from a normal polycythemia of intra-uteri life to that of a normal extra-uteri blood count, plus one other factor —immaturity in the liver cells.

CATARRHAL JAUNDICE

In catarrhal jaundice the onset is characterized by an acute febrile reaction with anorexia, nausea and at times vomiting before the appearance of jaundice. There may be pain but the constitutional symptoms are more evident and usually out of proportion to the amount of pain. There is fever, malaise, leukopenia with a relative lymphocytosis, a liver often times slightly enlarged and tender and the gradual appearance of jaundice. Special laboratory procedures are subject to too much variability to be of much assistance in this condition. The clinical picture above, occurring in young adults or early middle life nearly always represents acute catarrhal jaundice. Naturally the presence of other cases in the community is of definite confirmatory value. It may at times be confused with the jaundice of cholelithiasis which occurs in young pregnant women or women who have recently borne children. We are normally reluctant to make a diagnosis of gall bladder disease in young people, whereas we readily suspect catarrhal jaundice. However, the prevalence of gall stones in pregnancy is a well recognized clinical fact and is, as you know, attributed to hypercholesterolemia. One should also keep in mind toxic jaundice, such as that due to arsphenamine, lead, cinchophen, etc., as well as that which may be secondary to infection located primarily elsewhere (pneumonia, typhoid, malaria, etc.).

GALL BLADDER DISEASE AND MALIGNANCY

While many differential points, intended to exclude one or prove the other, have been promulgated, I have been convinced that in most cases we must simply go back to where we normally start, the history, for the most dependable assistance. Either a stone or a carcinoma may cause either partial or complete obstruction, thereby altering the findings in the urine and stool. We may have bile alone or both bile and urobilogen in the urine in both, although in neither do we find an excess of urobilogen alone. The stools in pancreatic carcinoma may show absent or

incomplete fat digestion, but that is not the rule. In both the icterus index and van den Bergh are elevated and we *expect* a direct rather than indirect van den Bergh. Finally, while we have seen carcinoma with pain and stones without, the fact remains that the gradual appearance of painless jaundice in a patient who is in the cancer age, especially when the previous digestive history is negative, is overwhelming evidence of malignancy. Additional weight is added if there is absence of fever and leucocytosis and, of course, presence of secondary anemia.

Stones, in a small percentage of cases, can be proved by x-ray. The dye test is of little value because impaired liver function incident to jaundice might prevent gall bladder filling even in the absence of obstructing stones. Here again the diagnosis usually must finally rest upon the history. In the absence of biliary colic, which, of course, speaks for itself, chronic indigestion, particularly that which occurs early after meals, plus pain however slight argues for stones. Cruvoiseus's law—a large palpable gall bladder in malignancy and a small (not palpable) one in stones—is worth remembering. It is far from infallible, but certainly sometimes helps. The jaundice of cardiac decompensation and atrophic cirrhosis are usually associated with fairly diagnostic signs and symptoms and need only to be kept in mind as a possible etiological factor in a mild, slowly developing but not entirely painless jaundice. It does not seem that there should be any confusion here, but I have seen jaundice of cardiac origin almost under the surgeon's knife and have seen in fact atrophic cirrhosis operated for gall stones.

TREATMENT

Apart from those cases in which therapy suggests itself by virtue of the underlying cause, there is no known treatment of particular merit. I have, therefore, elected to spare you and omit repetition of the well known measures of general application.

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County Distribution of Carcinoma Cases for 1930 in Wisconsin

Adams	2	Grant	9	Marquette	1	Sheboygan	1
Ashland	2	Green	9	Milwaukee	4	St. Croix	2
Bayfield	1	Green Lake	2	Oconto	3	Taylor	4
Brown	1	Iowa	2	Outagamie	2	Trempealeau	3
Chippewa	2	Jefferson	20	Pierce	2	Vilas	2
Clark	1	Juneau	5	Portage	6	Vernon	3
Columbia	8	Kenosha	5	Price	2	Walworth	8
Crawford	1	La Crosse	2	Racine	4	Waukesha	2
Dane	33	La Fayette	3	Richland	1	Waupaca	5
Dodge	2	Langlade	1	Rock	25	Waushara	2
Douglas	1	Manitowoc	1	Rusk	4	Winnebago	2
Eau Claire	1	Marathon	4	Sauk	7	Wood	6
Fond du Lac	8	Marinette	9	Shawano	2		
						Total	238

Intravenous Urography*

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The first attempt to render the urinary tract opaque to the roentgen ray, was made by Tuffier in 1897, who suggested the simultaneous combination of an opaque ureteral catheter and radiography. Schmidt and Kolischer in 1901 independently suggested the same method and published roentgenograms by means of a fused wire inserted into the ureteral catheter.

In 1905, Fenwich suggested the use of a ureteral bougie, its walls impregnated with metal.

Klose, in 1904, suggested the injection of an emulsion of bismuth into the renal pelvis and ureter.

Voelcker and von Lichtenberg, in 1906, first demonstrated successfully the complete outline of the ureter and renal pelvis in the roentgenogram by using a 2 per cent solution of colloidal silver.

A large number of solutions have been tried during the past twenty-five years, with a variety of methods to secure a visualization of the urinary tract by roentgenograms.

Fowler, in 1912, recommended taking one plate with the patient in the dorsal position and one in the erect position to demonstrate the degree of renal excursion.

In 1913, Schramm recommended the Trendelenburg position, in order to outline the ureter.

Young, Kelly, Braasch, Cunningham, Eisendrath, Kretschmer, Keyes, Lower, Necker, Kidd, Legue, Rehn, Pakin, Goldstein, Walker, J. W. T., and others have made valuable contributions to urography.

In 1923, Osborn, Sutherland, Scholl and Rountree, were the first to attempt the visualization of the urinary tract by means of intravenous injections of a 10 per cent solution of sodium iodide.

In 1924, Rosenstein and von Lichtenberg repeated the work with iodide in conjunction with perirenal pneumo-radiographic methods of Rosenstein.

Volkmann, in 1924, Lenarduzzi and Pecco in 1927, and Hryntschak in 1928 reported their findings.

Roseno was the first to achieve practical results by injecting a substance containing sodium iodide bound to urea.

UROSELECTAN

Uroselectan was synthetized in 1927 by Professor Binz assisted by Dr. Räth, and in November, 1928, he requested Professor Lichtwitz to investigate its value in the human. In March, 1929, he discussed it with Lichtwitz, and continued clinical work under Professor von Lichtenberg in Berlin, who selected the cases for investigation and appointed Dr. M. Swick of New York to clinically try out the preparation furnished by Binz.

Swick reported his findings at the Urological Congress in Munich in 1929, which were discussed by von Lichtenberg.

Iopax (Uroselectan) is a pyridin derivative with 42.1 per cent of organically combined iodine and on the basis of its synthesis the formula is that of a sodium salt of 2-oxy-5-iodopyridin-N-acetic acid.

Skiodan is a mono-iodo-methane sulphonate of sodium, an organic compound containing 52 per cent of iodine so firmly combined that it does not react even with nitric acid, sulphuric acid or silver nitrate. It is soluble in water up to 70 per cent at room temperature.

Abrodil is a white crystalline powder and is the sodium salt of iodo-methane-sulphonic acid (1C H2 So3Na) its molecular weight is 244, and contains 52 per cent iodine and is soluble in water up to 70 per cent room temperature.

INDICATIONS

Intravenous urography is indicated in (1) those cases in which, due to anatomical and pathological or technical reasons, it is impossible to use cystoscopy, ureteral catheterization or instrumental pyelography. (2) In

* Read before the Medical Society of Milwaukee County, March 13, 1931.

Fig. 1. Male, aged 5, pyuria, urethral stricture. Roentgenogram taken 30 minutes after intravenous iopax showing dilatation of bladder, and normal uretero-pyelogram.

cases of ureteral obstruction in which the pyelographic solution cannot be injected beyond the obstruction. (3) In those cases in which instrumental pyelography carries a risk for the patient. (4) Cases in which we can obtain sufficient information by means of intravenous pyelography, and (5) recently Necker and Chwalla have observed a beneficial influence on urinary tract infection from the intravenous administration of iopax.

Fig. 2. Male, age 34, right renal colic. Roentgenogram showing shadow in right renal pelvis.

CONTRAINDICATIONS

Intravenous urography is contraindicated in (1) Severe insufficiency of the kidneys. (2) Impaired liver function. (3) Active pulmonary tuberculosis. (4) Iodine idiosyncrasy. (5) Thyrotoxicosis, and (6) used with caution in children with exudation diathesis.

TECHNIQUE

A phenolsulphonephthalein test should always precede intravenous urography.

The patient is prepared by the administration of castor oil, one ounce, 24 hours before the injection, a soft diet the evening before. Fluids are withheld during the night, and the patient taken to the x-ray laboratory without breakfast and plate No. 1 is taken. Two glasses of water are given just before the injection is begun.

Thirty grams of iopax are dissolved in 110 cc. of fresh redistilled water, the powder being added little by little and under continuous stirring, the solution is then filtered into a beaker, heated to the boiling point, and kept boiling for ten minutes. The solution when cooled to body temperature will have a vol-

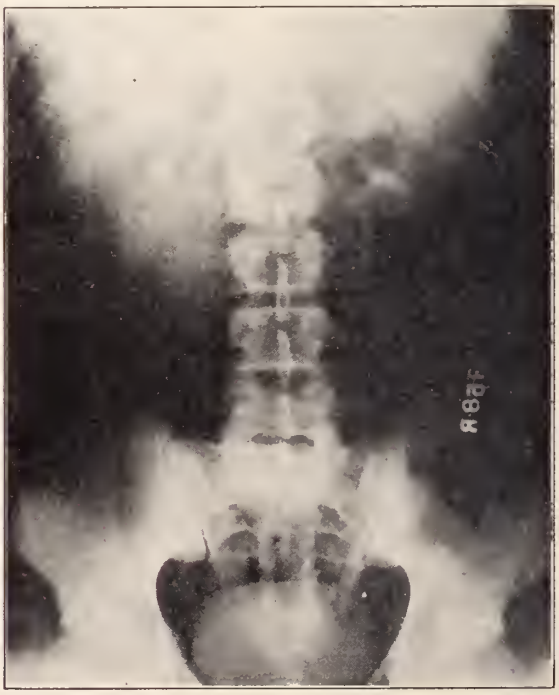

Fig. 3. Same case as Fig. 2. Roentgenogram taken 15 minutes after intravenous iopax showing calculi surrounded by iopax.

Fig. 4. Male, age 52, right renal colic, pyuria. Retrograde ureterogram showing dilatation of pelvic portion of right ureter, kink, and shadow at uretero-pelvic junction which obstructed the solution from entering the kidney pelvis.

Fig. 5. Same case as Fig. 4, showing hydronephrosis with iopax surrounding the calculi at uretero-pelvic junction.

ume of 100 cc. and should be injected slowly (ten to fifteen minutes) into a cubital vein.

Dosage for children: Infants 20 cc.; children up to 6 years 40 cc. and children 6 to 12 years 60 to 75 cc.

During the injection the patient's face may become flushed, there may be a change in the pulse rate, some experience a feeling of general warmth, and if the solution becomes cold, the patient will complain of pain in the arm and shoulder. There may be some dryness of the throat but these symptoms are transitory and disappear rapidly.

From 5 to 15 minutes after the injection is given, plate No. 2 is taken, and plate No. 3 in 45 minutes. When a fourth plate is necessary it is usually taken in 1 hour to 1½ hours, the bladder having been emptied before the exposure.

CASE REPORTS

During the past 10 months I have given iopax intravenously to 30 patients at Columbia, St. Luke's, and Milwaukee hospitals, Marquette and Milwaukee County dispensaries, which varied in age from 5 years to 88 years. In two cases in which iopax was given within 48 hours after retrograde pyelography, renal pain was complained of for 12 hours after the injection.

Gardner and Heathcote in an experimental study conclude that:

1. Uroselectan given intravenously in doses up to 6 grams per kilogram of body weight, has been shown to be non-toxic to dogs and rabbits, provided the rate of injection was not too rapid.

2. It depresses, in a strength of 0.8 per cent the muscle of both the isolated heart and intestine. The depression is, however, very slight.

3. When administered into vein in doses up to 6 grams per kilogram, dogs anesthetized with medinal. Uroselectan produced a fall in blood pressure; which may be preceded by a rise, if the blood volume is kept up, this fall is not serious.

4. No histological changes were found. The tissues of dogs rendered nephritic with uranium nitrate and then given uroselectan showed no other changes than those seen in control animals.

Fig. 6. Female, age 29, pyuria, ulcer of the bladder obstructing right ureteral orifice, retrograde uretero-pyelogram, right, showing kink at uretero-pelvic junction.

Fig. 7. Same case as Fig. 6. Roentgenogram taken 15 minutes after intravenous iopax showing bilateral visualization of upper urinary tract.

5. In dogs suffering from acute uranium nephritis, no evidence of the excretion of the drug by the kidney could be obtained.

Galbraith and Mackey studied the effect of intravenous uroselectan on animals, and reported that in no instances, even with the larger doses, was any toxic effect produced. Microscopical examination of kidneys failed to reveal any evidence of damage to the renal parenchyma, either immediately after the excretion of uroselectan, or at intervals up to 40 days after treatment.

Hyman, in reporting intravenous urography in 22 children (the youngest 6 months), considers it a most valuable diagnostic adjuvant; as it is non-toxic and does away entirely with all the disadvantages of retrograde pyelography.

Cooke reported two cases of polycystic disease that gave no shadow allowing of interpretation.

The older method produced typical pictures at once. In one such case, there was threatened uraemia with drowsiness, thirst, and a blood urea figure of 100 mgs. per 100 cc. of blood. In one instance no shadow resulted even with 60 grams of uroselectan.

Kretschmer emphasized that even though the desired data have been accumulated from the standpoint of pyelograms, it is still necessary, before surgical procedures are carried out on the kidney, to examine the patient with the cystoscope.

Herbst in January, 1931, reported a case before the Chicago Urological Society in which intravenous iopax produced no visualization of the right kidney pelvis or ureter. At cystoscopical examination the following day he found a normal functioning right kidney with normal right uretero-pyelogram.

DISCUSSION

Iopax is eliminated from the blood stream throughout the kidneys, normally: 45 to 65 per cent is eliminated the first two hours, and 20 to 30 per cent during the second two hours. Swick has recovered 98 per cent from two cases within 12 hours after the injection.

Iopax has been used as an intravenous pyelographic media by a large number of investigators throughout the world during the past year and found to be a safe and harm-

less laboratory test when used with discretion.

Much is to be learned from the interpretation of the plates.

The urinary tract is all too frequently forgotten in the diagnosis of both the acute and the ordinary abdominal case. There is no need to emphasize the value of pyelography in the diagnosis of an obscure abdominal or pelvic swelling, without instrumentation and with little disturbance to the patient, an injection of iopax may clear up a difficult problem of diagnosis.

CONCLUSION

Intravenous urography is a definite aid in abdominal diagnosis.

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N. T. A. PARTY TO HOLLAND

In connection with the Eighth Conference of the International Union Against Tuberculosis at The Hague and Amsterdam, Holland, September 6–9, 1932, the National Tuberculosis Association has announced plans for a special party to sail on the S. S. Westernland, August 26, 1932, for Antwerp. Tourist rates will prevail as the boat carries no higher class. Round trip tickets will be good for any length of time up to two years. Those interested may communicate with F. D. Hopkins, Executive Secretary, National Tuberculosis Association, 450 Seventh Avenue, New York.

The Effects of Heat*

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The recent protracted heat wave has given an opportunity to study the physical and psychic disturbances attendant upon exposure to excessive heat. Much confusion prevails over the differentiation of the several clinical forms of heat disturbance. The list of terms used is endless and we find heat exhaustion, heat stroke, sunstroke, insolation, thermic fever, siriasis, heat prostration, heat asphyxia, phoebism (to mention only a few) used synonymously. The "Nomenclature of Diseases and Conditions", issued by the U. S. Treasury Department and used in hospitals for classification purposes, recognizes only one term—"heat exhaustion". This term has been accepted because of general usage and includes all forms of illness brought on by excessive heat, either from direct exposure to sun's rays or indirectly from hot air. Heat stroke is a more logical term to be used for the group, reserving "heat exhaustion" for the syncopal form where exhaustion really plays an important role. Cases of sunburn with constitutional symptoms should be considered as a form of heat stroke.

Clinically, there are two distinct groups; one, manifested by syncope with pale, dry, clammy skin, rapid thready pulse, nausea and vomiting, headache and vertigo, and subnormal temperature; the other, usually characterized by flushed, dry skin, rapid weak pulse, elevated temperature and, in severe cases, hyperpyrexia, delirium and coma. To the first group we give the name heat exhaustion; to the second, heat stroke. The etiological agent is the same, but reaction of the organism is different. The reaction may depend on other factors. The stability of the vegetative nervous system is the most important factor, while fatigue and debility predispose to the syncopal form of reaction. Arterio-sclerosis, cardiac and nephritic disease, any debilitating systemic disease, and alcoholism predispose to pathological reaction to heat. Three cases, illustrating these two reactions to heat occurred on the hospital staff, June 29th.

Dr. E. L. had been nauseated and constipated for three days, had been restless and sleepless during the last of the hot nights, and did not perspire as usual. He had just been graduated and was working hard as interne in neuropsychiatry. On the morning of collapse he had made frequent trips up and down stairs engaged in his usual duties. At 10:30 he became very weak and vomited. Extreme pallor, dry skin, rapid thready pulse, headache and sub-normal temperature characterized his reaction.

A nurse on the same service, similarly engaged in activities requiring trips back and forth to the second floor had an identical reaction. She too had been unable to sleep, was extremely tired; had had headache for three days. Her syncope came on suddenly with vomiting, extreme pallor, dry skin, rapid thready pulse, sub-normal temperature and vertigo.

The same morning, a clerk in the department, not so actively engaged in physical activity and having no antecedent prodromal symptoms other than the usual discomfort due to the excessive heat, collapsed while walking upstairs. She became pale, weak and dizzy. Her pulse was rapid and thready and her temperature 103. Perspiration was suppressed. While the other two remained pale, with a return of syncope upon activity, her face became suffused with color after several hours. Her pulse continued to be rapid, while theirs became slow and weak. The latter recovered and was back at work in two days, while the other two had a definitely disturbed vasomotor system for 4 or 5 days. In the first two cases, fatigue due to lack of sleep may have determined the reaction.

However, both reactions are seen in the same case, one form merging into the other. The reaction varies in severity—from the milder forms described above to those with extreme degrees of temperature or with profound prostration. In the severe forms—

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temperatures above 105°, convulsions and coma are poor prognostic signs.

MENTAL SYMPTOMS

Psychic symptoms may sometimes mask the nature of the disorder—especially an isolated case occurring at a time when the heat is not excessive. In severe cases the psychic symptoms may be similar to those of acute delirium or of acute psychosis with disorientation, hallucinations, delusions and sullenness. Milder symptoms may occur. Simple depression is not infrequently seen. A mild state of euphoria with increased motor activity prevailed in the following case;

I. E., age 21, was admitted to the hospital complaining of severe pain in both legs. He had a temperature of 102° and was rather elated and hyperactive. Inconsistencies and variations in his story of his illness made us doubt his competency. Marked hyperesthesia, pain at slightest manipulation of his legs, pain in lumbar region, and psychic symptoms suggested an acute inflammatory disease of the nervous system. It was noted that his face, neck, upper chest and arms showed marked erythema. When he stated that he had acquired this a week before, we temporarily overlooked acute heat disturbance. However, when his mental state cleared up, it was learned that he had had a second and third exposure to heat while swimming two and three days previous to admission and since that time had had no appetite. He had slept with his clothes on several nights previous to admission. Neurological examination revealed only the findings mentioned above. His reflexes were normal. Blood pressure was elevated—(Cystolic 140), pulse rapid and thready. Lumbar puncture revealed the spinal fluid to be under increased pressure but cytologically and serologically normal. Blood count revealed a leucocyte count of 10,000. Red blood cells and albumin were found in his urine. He was admitted June 29th, and his fever continued until July 1st, when it dropped from 103 at midnight to 97.4 at 8:00 the following morning. With this drop the neuralgiform pains and mental symptoms completely disappeared, and his erythema had become a normal pink. There was no blistering or peeling of skin and it seemed that we are dealing with a case of heat stroke rather than sunburn, although albumin, granular casts and red cells indicate kidney complications which are more commonly seen in cases of acute sunburn.

The following case illustrates how the psychic symptoms may mask the true nature of the disorder, especially when it occurs during a period when heat is not excessive.

M. F., age 60, worked in her garden on May 27, 1929, in the hot sun without a hat. That evening and the three succeeding days she felt "nervous and irritable". On the morning of June 1st, she seemed somewhat irrational and physicians were summoned. At noon she failed to recognize anyone and had developed ideas of persecution. The evening of June 3rd, she took after her son with a butcher knife. She was brought to the hospital that night. She hadn't eaten or taken any fluids for two days because she thought everyone was trying to poison her. The urine showed a trace of albumin but was otherwise normal. Blood and spinal fluid were normal. The blood chemistry showed increase in both sugar (222) and N. P. N. (75) but this gradually returned to normal, and was thought to be due to concentration because of dehydration. Blood pressure was 160/95. Psychosis continued with fever, the latter subsided after a few days while the mental symptoms continued until the end of June. She complained of headache and dizziness daily. On June 13th, she had a syncopal attack with pallor, rapid thin pulse, low B. P.—(systolic 100), and elevation of temperature. There were no neurological or cardiac disturbances. During the first week of July she cleared up rapidly and immediately realized that she had had a sunstroke. She explained that the heat always affected her that way and that she had had the same trouble some years before from a sunstroke.

She was re-admitted May 24, 1930, following exposure to the sun while working in her garden, May 22 and 23. The reaction was similar to that of the year before, only less acute. On June 1st, she developed acute appendicitis with subsequent rupture and peritonitis. During this illness her mental symptoms cleared and she was discharged, July 12th.

A number of theories have been advanced to explain the reaction to excessive heat. An "infectious" etiology at one time received attention due to the findings of encephalitic foci and the term siriasis was introduced. It is now generally agreed that the underlying cause of heat stroke is a disturbance of the heat regulating mechanism following exposure to heat in a humid atmosphere. A male adult of 25, 5 ft. 10 in., weighing 154 pounds, under normal activity produces 2806 calories of heat in 24 hours. This is the amount of heat necessary to raise 7 gallons of water from freezing to boiling (1). 75% of this heat is eliminated by radiation and conduction from the skin and 24% by vaporization from the lungs. Sweating is the mechanism by which this heat is dissipated during excessive production. 100 gms. of sweat absorbs 58.6 calories. If the surrounding atmosphere is saturated with vapor, evaporation from the skin is suppressed and the body temperature rises. No heat can be lost by radiation when the surrounding atmosphere is hotter than the body and therefore sweating is the safety valve. Another important factor is a large fluid reserve held by muscles and skin available for dissipation of heat when the individual is exposed to high degrees of temperature. Symptoms of heat stroke appear when humidity is so high that evaporation cannot take place, or when the body reserve fluid is exhausted, or when sweating is suppressed by vasomotor action. When one's body temperature has been elevated, there is also a rise in heat production which may be accounted for by heating of the body cells (2). Either artificial or solar heat appears to exert the same effect.

The two forms of heat disturbance cannot be differentiated pathologically. Wohlwill (3) feels that we cannot draw tenable conclusions from post-mortem findings. He feels that the cloudy swelling of parenchymatous tissues, the reduction in the coagulation of the blood, and early rigor mortis are not intravital changes but in all probability are the result of the extreme heat which has hastened decomposition and mobilization of lactic acid. The important changes, according to McKenzie and LeCount (4), which are found in persons dying from heat stroke, are edema of the brain, generalized passive hyperemia of brain and lungs, pulmonary edema, cloudy swelling of liver, kidneys and myocardium, hyperplasia of spleen, petechial hemorrhages of various membranes and of the skin. The cause of death has been thought due to coagulation of cell globulin, coincident with chromolytic alteration of the nerve cells.

TREATMENT

Treatment is mainly symptomatic and the exhaustion cases must receive treatment different from those with "stroke". Therapeutic efforts are directed towards the vascular inefficiency. The overheated, pale, sweatless patient with sub-normal temperature needs stimulation for his peripheral vessels, and immersion in a bath 96°F and warm drinks should be administered. The individual with hyperpyrexia and cyanosed skin should be immersed in cool water and kept there until temperature reaches 104. The temperature will continue to go down after being removed from tub. If temperature rises again, he is to be returned to the cold tub when temperature reaches 103°. When sweating is restored, fluids can be increased to aid the body establish its normal evaporating mechanism, but in neither case should the patient be forced to excessive fluid intake. As long as suppression of sweat continues fluids should not be pushed in order not to overload vascular system, resulting in heart dilation and edema.

An ice bag will be welcome to head for discomfort there. Cardiac stimulants may be indicated just as in a state of shock. Ephedrine is better than adrenalin when the blood pressure is low.

The patient who has had a severe vasomotor disturbance should be kept in bed on light diet consisting mainly of milk, vegetables and fruit for 3 to 7 days. Debilitated persons may require a longer rest. Overheating should be carefully guarded against for the remainder of the summer. Medical care may be indicated over a longer period of time if any evidence of kidney damage has occurred, which is manifested by blood, casts and albumin in urine.

SECTION ON RADIOLOGY

H. B. PODLASKY, M. D., Editor

The Comparative Values of Retrograde and Intravenous Urography*

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The historical background for the visualization of the urinary tract by means of the injection of an opaque medium is well known from the time of von Lichtenbergs' pyelography to the present era of intravenous urography. However, one incident of experimentation in the evolution of this diagnostic procedure should be borne in mind in every discussion of the subject, and that is the work of Osborne, Sutherland, Scholl, and Rowntree[2] who in 1923 performed intravenous pyelography using sodium iodide. Owing to the imperfections of their preparations, however, they were unable to make the procedure practical.

The preparations which are in use at the present time are stable, organic iodide compounds. The first of these was selectan neutral which was introduced by Binz and Räth[3] in 1925 for the purpose of combating coccus infections. By the intravenous use of this agent they were able to visualize the urinary tract and this led to further efforts to obtain a product of less toxicity which would be capable of greater concentration. Roseno[4] came forward with pyelognos, which, however, was not satisfactory, and it was left for Swick[5] of New York to perfect a preparation which he called uroselectan. This preparation proved to be of practical application and immediately intravenous pyelography became a prominent roentgenologic procedure. Since then the preparations of skiodan and abrodil have been brought into use. These contain 52 per cent of iodine as compared with uroselectan which contains only 40 per cent. The latest preparation, neo-iopax, is in solution and may be injected directly from the sealed ampoule.

It is possible by means of these newer preparations to use an injection of 20 gr. as against the 40 gr. necessary with the former preparation. The total quantity of solution used in each instance, however, is 100 c. cs. which is injected by the gravity method. In our experience no untoward reaction has followed this procedure.

These later preparations are excreted more rapidly which necessitates taking films immediately after the injection and at more frequent intervals than was necessary with the old preparations.

Urography by the intravenous method is a practical procedure with almost no contraindications except in cases of glomerular nephritis where excretion is at the minimum. By this method the entire urinary tract may be visualized. A very accurate determination may be made of the integrity of the kidney and its ability to excrete through the glomeruli, amounting to virtually a visual estimation of kidney function.

While this method does not give a precise result, von Lichtenberg states that it is satisfactory for clinical interpretation and judgment of a surgical lesion. Perhaps a fair estimate of elimination is about 90 per cent in the first hour, and in cases in which no concentration is shown in the first half hour the kidneys may be definitely considered to be functionally impaired.

Intravenous urography then becomes a wonderful complement to cystoscopy and should be considered as an adjunct to the older methods of examination. On the other hand, its indiscriminate use as a short cut to diagnosis must be condemned, and it should in no sense be considered as comparable with pyelography by the catheter method; but its use is definitely indicated where retrograde pyelography can not be done, or where both kidneys are to be inves-

* Presented before Radiological Section, State Medical Society of Wisconsin, Milwaukee, May, 1931.

tigated and bilateral injection is contra-indicated.

The visualization of the kidney pelvis and ureters by intravenous urography is of necessity only a functional process and may be compared to the colon examination made after an ingested opaque medium which usually shows the colon partly filled in contrast to that in which the colon is completely filled with a barium enema. This at once gives us some idea of the comparative difficulties in interpretation, particularly in the case of the normal kidney, when perhaps only 50 per cent are filled sufficiently to rule out pathology.

It would seem then that catheterization and injection of the kidney pelvis and ureters is the method of choice in the vast majority of pyelographic examinations, as by this method specimens may be obtained from both sides, which is particularly advantageous in cases of infection.

There are many cases, however, in which catheterization is impossible or at least impractical. These might be divided broadly into three classes: (1) cases in which anatomical or pathological conditions preclude cystoscopy, (2) when obstruction prevents injection of the solution beyond the point of obstruction, and (3) those cases in which instrumentation becomes a risk to the patient. To enumerate some of these conditoins more explicitly we would first mention cases in which the ureters have been transplanted into the colon; cases of ureteral obstruction, such as a large stone; stricture of the ureter; or tumor of the ureter (in many of these cases it is extremely important to know something of the condition of the kidney and ureter above the point of obstruction); diverticulosis of the bladder in which the ureter opens into the diverticulum and the introduction of a ureteral catheter is impossible; extensive papillomata or other tumors of the bladder, which obscure the ureteral orifice; enlarged prostate or stricture of the urethra, making cystoscopy impossible; the presence of only one kidney, either a congenital solitary kidney or a single kidney left after nephrectomy (in these cases the urologist many times hesitates to do a pyelogram on the only remaining kidney); cases of marked cystitis with edema of the bladder wall, sometimes with marked hematuria; tuberculosis of the kidney in the presence of which many authors consider it inadvisable to do bilateral pyelography.

Many times the suspected kidney may be examined by retrograde pyelography and the pathology definitely determined, yet it becomes of importance to determine the kidney function and the possibility of a similar infection in the opposite kidney. In many instances this can be very nicely done by intravenous urography. Anomalies of the kidneys and ureters may be very well demonstrated by this method, particularly polycystic kidneys which are usually bilateral and have a rather poor function; also in the case of nervous individuals where cystoscopy can not be performed without anesthesia. In the urologic conditions of childhood, intravenous urography should at least be the first procedure to be attempted and in most instances will give very definite information as to the condition of the urinary tract.

Many authors have cited hydronephrosis as an ideal condition for the demonstration of intravenous iodide. I wish to call your attention to the fact that most hydronephroses are of an intermittent type and unless such an examination is done at the time of actual obstruction there will be little or no retention and we will either miss entirely or vastly underestimate the amount of hydronephrosis present.

Interpretations of urograms made by intravenous urography embody most of the principles of diagnosis or interpretation which are obtained by retrograde pyelography. There is this difference, however, that by the former method only the urine contained iodide is seen in the functional process and peristalsis may empty a single calyx or the ureter and thereby cause filling defects which may be interpreted incorrectly. To avoid this, a considerable number of films should be made as is done in a study of the duodenum after barium in an attempt to get a well filled duodenal bulb.

As previously stated, great care should be exercised in estimating the amount of hy-

dronephrosis present in a given case or in deciding the presence of a moderate hydronephrosis which is often seen in ptosis of the kidney or any early obstruction of intermittent character as the kidney may be functioning well at the time of such an examination. The same applies to the extensive infection of the kidney with poor function. Calculi may be accentuated and more easily visualized by this method as compared with their complete obliteration in retrograde pyelograms. The anomalies are well determined and offer no great difficulty of interpretation.

SUMMARY

I feel that with some experience the findings from intravenous pyelograms, ureterograms and cystograms will offer only moderate difficulty. You may be discouraged by many unsatisfactory examinations but by perseverance these difficulties will be overcome, as has been the case in cholecystography due to improvement in technic and careful attention to details.

Intravenous urography, then, has added a very valuable method to our urological diagnostic armamentarium and has come to be a practical roentgenologic method of examination in cases in which a pathological condition in the urinary tract is suspected.

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DISCUSSION

Dr. James C. Sargent (Milwaukee): It would be ungrateful not to express my real appreciation for being given the privilege of your floor, particularly in the discussion of such a complete and timely paper as that which we have just had the privilege of hearing. It is my personal opinion that this subject is of exceeding importance both to urologists and roentgenologists, and I have the feeling that the development of the Selectan group of drugs marks the greatest advance in radiology since the advent of gall bladder visualization and the greatest advance in urology since Burns' development of thorium nitrate as a reasonably safe and reliable method of retrograde pyelography.

It is idle for me to attempt to enlarge upon the subject so lucidly presented by Dr. Nichols and I can only hope to stress several points which I consider to be of unusual importance regarding the whole subject of Selectan drugs.

Dr. Nichols has pointed out that one of the large advantages of intravenous pyelography is that it makes possible a fair visualization of the urinary tract in those not by any means unusual instances in which for one or another reason retrograde pyelography is impossible. I present this Uroselectan film of a nine year old child with bilateral hydronephrosis in illustration of this point. Those of us who have had to do pyelography on small children under anesthesia can readily appreciate the large advantage that this newer method gives. I should like also in this film to point out the interesting, and often very worth while, fact that the soft tissue shadow of the kidney is sharply accentuated during the excretion of the Selectan drugs. In this film you will note that, though the hydronephrosis in the right kidney, as measured by pelvic capacity, is more advanced than that in the left, the extremely thin renal cortex in the left kidney tells us beyond peradventure that the right kidney is far the better kidney from the standpoint of function and of functional reserve.

Though there are many factors that influence the density of the shadow seen in intravenous pyelography, if they are all taken into consideration and properly discounted, the procedure does in fact offer a fairly usable guide to the comparative function of two kidneys. The first of these two films shows a large stone impacted in the upper ureter and sufficiently tight to forbid retrograde injection of that kidney pelvis. Under such circumstances the ordinary assumption would be that the kidney was completely destroyed and that nephrectomy was indicated. The Uroselectan film shows, however, that the kidney is still able to throw out the drug in fair concentration and suggests that removal of the stone would result in the saving of a comparatively good functioning kidney. This assumption was vindicated by nearly complete recovery of the kidney following uretero-lithotomy.

In contrast, here is a patient with a moderate degree of hydronephrosis in which a retrograde pyelogram not only shows the anatomical condition but suggests the tempting possibility of a plastic repair. The Uroselectan film, however, proves, even after an hour and a half, that none of the drug has been excreted by the kidney and strongly suggests that the kidney is completely and permanently functionless.

One cannot pass the subject of this new group of Selectan drugs without commenting upon the remarkable improvement they offer as media for re-

trograde pyelography. The shadow cast by any of these drugs injected through the ureteral catheter is infinitely more clear and sharp than that of any of the prior drugs and, what is of much greater significance, at least to us urologists, if the fact that such injection is absolutely painless and, the drug being not irritating, never results in the extremely disturbing and occasionally serious postpyelographic consequences that we have been so used to.

Again let me thank you for the privilege of hearing and discussing this paper and compliment you upon its completeness and clearness.

THE JOURNAL CLINIC

Spontaneous Pulsating Exophthalmos; With Case Report

By EDWIN C. BACH, M. D.
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Since the year 1805 there have been approximately 600 cases of pulsating exophthalmos reported in the literature. It is therefore not as rare a condition as one might suppose—but because the symptoms are very disturbing to the patient, and the consequences to the eye serious, the report of this case will be of interest.

Etiology: Pulsating exophthalmos may be either spontaneous or traumatic in origin. C. E. Locke in his analysis of 544 cases, gives the following figures: 126 or 23% were of spontaneous origin and 418 or 77% were of traumatic origin. The spontaneous type occurs later in life and is much more common in women—the average age being toward the end of the 5th decade. The traumatic type is more common in men—the average age being toward the end of the third decade. Bilateral pulsating exophthalmos is more common in the traumatic type.

Pathology: Locke reports the autopsy findings in 50 cases. Of this number 33 were performed on spontaneous cases and 17 on traumatic cases. Of the 33 autopsies, 16 showed communication between the internal carotid artery and the cavernous sinus; 7 were caused by tumors, 3 were caused by simple aneurism of the internal carotid, and 3 by simple aneurism of the ophthalmic artery. There were 5 in which no lesion was found but 2 of these had been cured by operation before death, and in another an incomplete examination was made.

Of the 17 autopsies on the traumatic cases, 16 or 94%, proved to be an arterio-venous communication between the internal carotid and the cavernous sinus, and only one case of aneurism of the internal carotid.

In the spontaneous type about 50% were found to be caused by an arterio-venous aneurism between the internal carotid and the cavernous sinus, 25% were caused by simple aneurism and 25% were caused by tumor.

From the autopsy findings of these 50 cases one can conclude that nearly all cases of the traumatic type of pulsating exophthalmos are due to arterio-venous aneurism between the internal carotid and the cavernous sinus.

Topographical Anatomy: The internal carotid and the cavernous sinus are in intimate relationship and immovable along the body of the sphenoid from the supra-orbital fissure to the apex of the petrous portion of the temporal bone. The 3rd, 4th, ophthalmic and maxillary division of the 5th, and the 6th cranial nerves are in contact with the cavernous sinus in this same locality.

Symptoms and signs: The chief symptoms are: Proptosis and restricted motility of the eyeball, edema of the lids and conjunctiva, dilated veins of the eye lids, especially above the inner canthus, pulsation of the eye ball, bruit, which is often subjective as well as objective, and, ophthalmoscopically, engorged retinal veins usually accompanied by changes in the optic disc and occasionally in the retina.

Diagnosis: The outstanding signs of pulsating exophthalmos makes the diagnosis easy, but the underlying pathological cause is not always easy to determine. The

aneurismal types are more apt to occur in elderly people. The simple aneurism may at any time become an arterio-venous one, if it is of the internal carotid. In the arterio-venous type the exophthalmos is more marked and the bruit louder.

If of traumatic origin, the chances are in favor of an arterio-venous aneurism. In orbital tumor the onset is very gradual and the bruit absent or very feeble.

Prognosis: Prognosis relevant to life is good but for vision is bad. DeSchweinitz and Holloway report that about 20% of these eyes terminate in blindness, and not more than 11% retain normal vision. Optic atrophy is a frequent sequel in this condition. The cornea also frequently suffers.

TREATMENT

The treatment is based on methods which will cause stasis of the blood stream, or a thrombus formation in the veins, or in the aneurism itself. This has been accomplished by the following procedures:

1. Digital compression of the carotid. One hundred and six cases have been treated in this way with 26% cured or improved.

2. Ligation of the common carotid. In Locke's series of 84 cases in which this was done, 68% were cured or improved with a mortality of slightly over 7%. In DeSchweinitz's and Holloway's series of 34 cases in which this was done, 50% were cured or improved with 11% deaths.

3. Ligation of the internal carotid: Records of 38 cases of Locke's and DeSchweinitz's cases show that 86% were cured or improved with a mortality of about 8%.

4. Bilateral ligation of the common carotids: The records of 21 available cases show 62% cured or improved with a mortality of 14%.

5. Ligation of the orbital veins: This was first done successfully in 1874. Since then about 43 cases have been treated in this way with 69% cured or improved and 11.5% deaths. In many of these cases there has been a previous carotid ligation. In 19 cases ligation of the orbital veins was the primary operation and of these 68% were improved or cured and 5% died.

6. Rest and Medication: Records of 28 cases thus treated show that 14% were cured, 36% improved, 4% died, and the remainder got negative results.

Fig. I.

7. Subcutaneous injections of Gelatin: 16 cases were treated by this method. 62% were cured or improved while the remainder were more or less unchanged.

CASE REPORT

B. W. A woman, aged 63, born in Germany and living in this country for the past 50 years. She is married, and a housewife by occupation. Eight brothers and sisters; five living. One died of pneumonia at the age of 10 months, one died of diabetes (?) at the age of 1½, one brother killed in the World War.

She had several of the usual diseases of childhood, and at the age of 22 she had typhoid fever, from which she made an uneventful recovery. Since this time she has been in good health except for two accidental falls. The first fall occurred about three years ago and she was confined to bed about two weeks with a "lame side". The second fall occurred about a year ago, following which she was confined to bed with "water on the knee" for two weeks. She did not injure her head in any way in either of these falls.

About a year and a half ago she began to suffer from an occasional headache. These headaches were not bad and she did not give them much thought. Last spring she began to have occasional dizzy spells and during the summer following, the headaches became slightly more frequent and more

severe. These headaches were "all over" her head but at times more on the right side. Aspirin would relieve these headaches. The headaches would come once or twice a week. During the month of November she felt somewhat improved and had only a few headaches.

Late in the afternoon of November 28th, after a strenuous day in the laundry, she began to feel weak and nauseated. She was dizzy and had a slight headache and was forced to leave her work and lie down. Toward evening she felt worse and vomited several times. The family doctor was called and gave her a hypodermic after which she felt better and slept. At about 5:30 the following morning, she awoke and noticed that her eye felt "numb" and that there was some bleeding from the inner corner of the eye. Since the bleeding was not much in amount, the doctor was not called until later in the day.

PHYSICAL EXAMINATION

A well nourished women about 5 ft., 5 in. in height and weighs about 130 pounds. She appears to be quite comfortable and composed. Her mentality is normal and she answers questions intelligently.

Externally the right eye shows an extensive edema and ecchymoses of the lids and surrounding part of the face. There is a high degree of proptosis. Palpation reveals that the lids and eye ball are under a high degree of tension, and pulsate in synchronism with the radial pulse. The eye ball is fixed in straight forward position. Auscultation over the eye and right temporal region reveals a loud systolic bruit. The lids are partly anaesthetic, and pressure against the eye causes no pain.

The conjunctiva is very chemotic, and there is considerable subconjunctival blood. The exposed lower part of the cornea is slightly hazy. The anterior chamber is of average depth, the iris normal in appearance. The pupil is slightly smaller than normal and does not react to light. There is no light perception, and no fundus reflex present.

The edema of the lids has spread over slightly to the lids of the left eye. In other respects the left eye is normal in function. The veins of the fundus are slightly enlarged.

Ears, nose, throat and teeth negative.

Neck negative.

Chest: The lungs are normal. The heart is somewhat enlarged downward. There is a systolic murmur over the mitral area and a slight diastolic murmur heard over the aortic area. The rate and rhythm is good. The radial arteries show marked sclerosis. The temporal arteries do not show this change. The blood pressure is 200 systolic and 115 diastolic. There is no edema, cyanosis or dyspnoea.

The abdomen is normal in size and contour. There are no scars herniae, or palpable masses. No rigidity. There is a generalized tenderness.

G. U. Menopause at 50. No nocturia, no dysuria.

The knee jerks are equal and active.

The skin is clear.

Wassermann and Kahn: negative.

Blood: R. B. C. 4,690,00. W. B. C. 22,000. Hb. 88%. Polys. 84%. Small lymphs. 14%. Large mononuclears 2%.

Urine: Amber, cloudy, Sp. g. 1.020 Albumin, trace. Sugar, negative. 5 to 20 leucocytes.

PROGRESS OF THE CASE

Shortly after admission to the hospital on November 29th, it was thought advisable to lower the blood pressure promptly. A venesection was done and about 500cc of blood removed. The blood pressure after this came down to 120 systolic and 80 diastolic.

November 30th—Her condition was unchanged. She complained of feeling nauseated and was unable to take foods or liquids. She vomited several times during the day.

December 1st—The blood pressure was 168—110. She still felt nauseated at times. The eye had not changed.

On December 2nd the blood pressure had arisen to 200—115. The proptosis was slightly more pronounced. The pupil was slightly irregular and the anterior chamber contained blood. She felt better and was able to eat a little.

On December 4th the blood pressure was 190—112 and she complained that she had a throbbing, rushing sound in her head. Auscultation over the eye revealed that the bruit was very loud, and seemed to be louder than previously. At this time digital pressure was tried on the carotid and the pulsation and subjective bruit promptly stopped. The pressure was maintained for about two minutes and no bad results were noted by the patient. It was decided to ligate the common carotid.

December 5th—Under ethylene anasthesia, Dr. J. Carroll ligated the common carotid with double ligatures of chromic cat gut. The vessel was partly occluded for about 5 minutes and then the ligatures were put on tightly. After ligation of the common carotid a very faint, almost imperceptable pulsation of the eye persisted.

December 6th and 7th—She felt quite well. The subjective pulsation had stopped and nothing could be heard with the stethoscope. To palpation there was a very slight pulsation. The swelling was less.

December 8th—The prolapsed conjunctiva is becoming covered with a fibrinous exudate. During this time there was a continuous serous ooze and the eye was dressed with vaseline and a bandage daily.

December 11th—She had a rather restless night. No pulsation could be felt in the morning. In the evening she complained of a pulsing rushing sound in the right ear and auscultation revealed that a faint bruit had returned.

December 12th—She complained of a right sided headache which bothered her most of the night. The noise in her ear had stopped. Examination showed that the swelling was more pronounced. There was no pulsation to palpation and nothing could be heard.

December 13th—The right sided headache is not so bad but still present. She complains of feeling weak.

December 14th to December 19th—Her head bothers her a little. She has no complaint concerning the eye. There has been no subjective or objective bruit since December 11th, and the pulsation has stopped. The bulbar conjunctiva is beginning to slough away. The eye is soft and insensitive. It is in a degenerated condition, and enucleation was advised.

December 19th—An application of 10% cocaine was made to the tarsal conjunctiva and the eye was enucleated without other anaesthesia. She felt no pain during the operation. Examination of the eye ball revealed that the sclera was very friable and the eye ball filled with an old blood clot.

April 26, 1931—Since she left the hospital she has felt quite well. The swelling had subsided completely. For a week during March the bruit was present both subjectively and objectively, but it soon disappeared again. For the past two weeks she has been having hallucinations of vision at times.

CONCLUSION

The unusual features of this case are: the sudden onset, the retrobulbar hematoma, and the massive intraocular hemorrhage.

It is possible that the headaches, which began about a year and a half ago and which were often on the right side of the head, were caused by a growing aneurism of the internal carotid within the cavernous sinus.

The hemorrhage which occurred behind and also within the eye was undoubtedly due to rupture of retrobulbar and intra-ocular veins. The large ophthalmic vein, which runs into the cavernous sinus thru the supraorbital fissure, lies in the fat of the orbit and has little outside support. Other venous channels connected with the cavernous sinus either lie between layers of dura or are covered with dura and are well supported. It is reasonable to suppose, therefore, that the ophthalmic or some of its branches ruptured when they were subjected to the arterial blood pressure; especially so because the patient had a moderate degree of hypertension.

On December 11th when the bruit and pulsation ceased and when there was a slight increase in swelling with right sided headache, it was concluded that thrombosis of the orbital veins and probably of the cavernous sinus on the right side had occurred.

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Crush Fractures of the Spine; Immediate Treatment by Manipulation; With Report of Cases*

By LEMUEL DAVID SMITH, M. D.
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Early actual reduction of crush fracture of the vertebrae should apparently be as desirable as early accurate reduction of appendicular fracture.

The close relationship of this fracture, with vulnerable nerve tissue and the frequent association of neurologic disturbance with this injury, increases the gravity of the problem and counsels conservatism in their management. A method of manipulation must have as its object not only the reduction of the fracture but the conservation of the spinal cord and its roots. Such a procedure, if successful, would facilitate convalescent care. The maneuver suggested by Dr. Arthur G. Davis[1] appears to possess these advantages.

CASE REPORTS

Case I. J. W.: A painter 61 years old fell 15 feet with a ladder. He was unconscious five to ten minutes, then complained of pain in the low back. There was a moderate kyphos in the dorso lumbar region.

The roentgenogram (Fig. 1) showed a

* Read before The Milwaukee Academy of Medicine January 27, 1931. (From the Department of Orthopaedic Surgery, Marquette University School of Medicine.)

[1] Dr. Arthur G. Davis, "Fractures of the Spine"; Journal of Bone and Joint Surgery; Vol. XI.; No. I, January; Page 133; 1929.

Fig. 1. This roentgenogram shows a crushed fracture of the first lumbar vertebra. (Case I).

Fig. 2. This roentgenogram shows the restoration effected after manipulation. (Case I).

crush fracture of the first lumbar vertebra. Four days after the accident an attempt at reduction was made under deep anaesthesia. The roentgenogram (Fig. 2) indicates the restoration effected. The roentgenogram (Fig. 3) five months later indicates normal calcification. There were no neurologic symptoms before or after the manipulation.

Case II. L. W.: A woman 43 years fell to the ground from a second story veranda, August 15, 1930. There was an immediate complete paralysis from Poupart's ligament downward. There was a prominent kyphos at the dorso lumbar junction. The roentgenogram (Fig. 4) taken the same day showed extensive crush fracture of the first lumbar vertebra. The next morning her spine was manipulated with the patient under deep anaesthesia. The roentgenogram (Fig. 5) shows restoration of the architecture of the centrum and the reestablishment of the physiologic lumbar curve. There was retention incontinence of bladder and rectum. This corrected itself spontaneously in four weeks. Troublesome decubitus ulcers developed early. The last one healed January 1, 1931. Evidence of returning sensory conduction was obvious five weeks after the injury. This function continued to improve until it was practically normal January 1, 1931. Revival of motor function has lagged. The patient had control of the thigh muscles by January, 1931, but not motor control below the knees.

DISCUSSION

Dr. Joseph M. King (Milwaukee): Dr. Smith has secured a nice reduction in the case of the woman—the case with cord symptoms. I am just wondering whether Dr. Smith believes that a laminectomy following his reduction would have helped?

We have all seen these cases, especially in county institutions. They live for months and even years, helpless cripples, many of them with large trophic ulcers on the buttocks and thighs and they are pitiful sights. After a time the usual course is an ascending infection of the urinary tract with death in uremic coma as the final picture.

The other x-ray is not quite so clear, but perhaps the manipulation which Dr. Smith did, has facilitated early fusion and prevented the so-called Kümmell's disease where there is gradual absorption of the body of the vertebra with resultant cord symptoms. I will be interested to learn just what kind

Fig. 3. This roentgenogram shows normal calcification five months after fracture. (Case I).

Fig. 4. This roentgenogram shows extensive crush fracture of the first lumbar vertebra. (Case II).

of manipulation Dr. Smith used, for I hope he has not stolen any tricks from the boys in Davenport.

Dr. Eben J. Carey (Milwaukee): According to the evidence presented by the roentgenograms, Dr. Smith has obtained excellent results in the immediate reduction of this spinal fracture by manipulation. I would like to have Dr. Smith explain his method of reduction by manipulation.

Dr. Frederick J. Gaenslen (Milwaukee): The result obtained by Dr. Smith in these two cases is very excellent indeed. As a rule the reposition of ordinary methods of procedure leaves much to be desired. I shall be glad to hear the technique described. In this connection I should like to report the case of a young woman of about twenty-five years of age who, while walking along the highway, was hit by an automobile. Dislocation occurred between the 4th and 5th lumbar vertebrae. The 4th lumbar vertebra being displaced to the left on the 5th, a distance of about four-fifths of the width of the vertebrae. There were fractures of the pedicles and articular facets. Very extensive, but not complete, motor and sensory paralyses were present.

Attempt at reduction was made as follows: The patient was placed on the Hawley fracture table in the supine position with the feet securely strapped to the foot supports. The patient's entire trunk was then painted with Heisner's glue and a closely

Fig. 5. This roentgenogram shows restoration of architecture of the centrum and the reestablishment of the physiologic lumbar curve. (Case II).

fitting stockinet applied, firmly bandaged to the trunk with a broad elastic bandage. The stockinet reached to the hips and extended beyond the head for a length of six or seven feet. Holes were cut for the arms and for the face. Spinal anesthesia was used. Three men then made traction on the free end of the stockinet extending beyond the head, while I manipulated the spine, guided by x-ray findings. The method proved very efficient, the stockinet withstanding the enormous pull without giving way. After a few seconds of this traction and manipulation, to my great surprise, there was a loud report, such a report as one might expect on the reduction of a traumatic dislocation of the hip. This was accompanied by a palpable thud and a correction of the previously apparent disturbance of contour.

I was entirely unprepared for such a loud report but felt that a reduction could be assumed, and that there would be little danger of relaxation. X-rays were taken on the table and showed a very satisfactory reduction. To my chagrin, some six or seven weeks later another x-ray showed a partial recurrence. A second attempt was therefore made in a similar manner with only fairly satisfactory results, but continued traction on the trunk and lower extremities maintained fair reduction. Recently, a year after the injury, the patient walked into my office. There was evidence of slight motor disturbance, while sensory disturbance was practically completely corrected.

I have taken the liberty of describing this technique in detail as these cases are unusual and difficult to manage. So far as I know this type of traction has not been used before. The method should be applicable in cases of fracture dislocation in the lower dorsal or lumbar regions.

Dr. L. D. Smith (Milwaukee): The problem of laminectomy or cordotomy is a debatable one. This treatment is not suggested as an alternative to open operation if or when it may be indicated. It would facilitate such procedure as the normal anatomic relationships would have been partially restored.

The method used is as follows: we have placed a beam in the light well of the plaster room about which is a chain to which is attached a hook of a block and tackle system, the other hook of which is applied to several figures of eight turns of bandage about the ankles of the prone patient. The patient is suspended until the symphysis pubis is just free from the table. The weight of the patient becomes counter traction and the leverage of the thighs produces hyperextension of the spine. The gibbus may be manipulated with facility. It is a stimulating experience to see the hump mysteriously melt away under the manipulation. At the same setting a plaster of Paris posterior shell is applied extending from the top of the head to the heels, with the spine in the over corrected hyperextended position. Immediately the patient is turned to a supine position on this posterior shell and an anterior plaster shell is made extending from the chin to the malleoli. The motive for presenting these cases is to offer the suggestion that in some instances of compression fracture of the spine, (a) the architecture of crushed vertebra may be restored, (b) where there were no neurologic symptoms this treatment may not be followed with neurologic symptoms (c) where the paralysis was complete and immediate below the lesion the maneuver may be followed with partial remission of the neurologic symptoms.

The plaster shells maintain the corrected position and facilitate handling and care of the patient. The patient can be alternated from the supine to the prone position which is an obvious physiologic advantage. This change of position not only promotes the comfort of the patient but may help prevent distressing atrophic ulcers.

Varix of the Umbilical Cord; With Case Report

By ROBERT E. McDONALD, M. D.
Milwaukee

It is my purpose in citing the following case to add one more report of a varix of the umbilical cord to the very meager literature on the subject of umbilical cord tumors, especially those of vascular origin.

LITERATURE AND DISCUSSION

In 1928, I was prompted to review the literature regarding the incidence of tumors of the umbilical cord, particularly those originating from the vessels, and report a case in conjunction with F. L. Adair.[1] The woman was delivered on our service* of a seven and one-half months dead fetus with a tumor the size of a grapefruit situated in the middle of the umbilical cord. The tumor, which a thorough examination proved to be a varix, had ruptured and caused the intrauterine death of the fetus by exsanguination.

A very small number of cord anomalies were reported and among these only four[2 3 4] had been definitely proved to be varices. Another case suggesting varix was not positively so diagnosed.

Tumors arising from the umbilical vessels are not common, though no doubt the few cases reported in the literature are no criterion of their actual incidence. Practically

* From the obstetrical service of the Minneapolis General Hospital, 1928.

speaking these cases present no informative data of therapeutic value since there obviously can be little or no treatment. The finding is entirely an incidental one after the birth of the baby but may, in the very rarest of cases, explain the death of an otherwise normal infant.

In four of the five cases reported prior to the one in this article, the babies were stillborn due to rupture of the varix with resultant exsanguination. In general, death of the fetus must result from one of two causes: rupture of the varix wall in the larger types, or from diminution or complete block of the blood supply by clot formation in the smaller ones. In the four cases of fetal death occurring in the aforementioned cases, all deaths were due to the first cause. In the fifth case,[4] in which the infant lived, the varix was pediculated and communicated with the vein by an elongated "neck". Failure of the varix to rupture in this instance may have been due to a lower vascular tension in the sac than that within the vein proper.

The following case history will demonstrate the second possible cause for death of the fetus, (though, fortunately, this baby was saved) i. e. clot formation within the varix with diminution or complete block of the arterial blood from the mother to the child.

REPORT OF CASE

D. K., a multipara, twenty-five years old, was admitted to the hospital March 18, 1931, in labor at term. Delivered in 1928 of a male infant, full breech, and in 1929 of a female infant, frank breech. Family history negative. Past history, except for scarlet fever during early childhood, of no consequence. Last menstrual period began June 5, 1930, after having menstruated only once since the birth of her second baby. Expected date of confinement about March 12, 1931. Patient had pre-natal care throughout her pregnancy and a diagnosis of breech, R. S. A., was made at eight months. External version accomplished conversion to O. L. A. which was retained.

Physical Examination.—The patient was a woman of medium stature, moderately obese but well developed. Heart and lungs normal. Blood pressure varied between 110/70 and 116/74 throughout pregnancy and labor. Abdomen usual ovoid type of pregnancy with the fundus palpable three finger breadths below the xiphoid process of the sternum. Palpation revealed the breech in the fundus, back on the left side anterior, small parts to the right and the head engaged in the pelvis. The fetal heart was heard at an average rate of 130 in the left lower quadrant of the abdomen. There were no toxic signs or symptoms.

Pelvic measurements: External—23.0; 25.5; 30.0; 19.5; 9.0. Internal—Diag. Conj. 12.0; C. V. 10.5.

Labor lasted nine and one-half hours of which nine hours and five minutes were in the first stage. The membranes ruptured early in the second stage, permitting escape of a normal amount of clear amniotic fluid. The fetal heart rate up to the last forty minutes of labor varied between 128 and 136 per minute with tones of good quality. During the forty minutes just before delivery the fetal heart rate began to increase steadily until the head reached the perineum when it was counted at 166 beats per minute and weaker in quality. Low forceps were applied to the head in O. L. A. and the baby was quickly delivered in a condition of asphyxia pallida. Male infant, well developed and weighing eight pounds seven and one-half ounces. A tumor, dark reddish blue in color and about the size of a small walnut was noted close to the junction of the skin and the umbilical cord. The cord was ligated about two inches distal to the tumor and immediate efforts were made to resuscitate the baby. This was accomplished after twenty-two minutes during which time alpha lobelin ½ c. c. was given, warm water tubbing and oxygen for stimulation, and intra-tracheal breathing per catheter. After twenty-two minutes we were rewarded when the baby began to breathe regularly and its color became a healthy pink. Five minutes later the cord was ligated more securely, this time close to the skin margin. The tumor was then incised and a blood clot the size of a large pea was expelled revealing a dilation in the vein slightly larger than the size of the clot. The

side of the vein wall to which the clot had been attached was roughened while the opposite wall presented a smooth glistening surface. To reconstruct the picture, it was possible to see that the lumen of the vein had been markedly reduced by the presence of the clot though it was still possible for a greatly diminished stream of blood to pass to the fetus.

The clot was of soft consistency and was not as yet organized, indicating that it had probably been forming during the few hours or minutes of labor. It seems reasonable to presume that the clot could not have been forming for very long since its texture indicated a rather rapid formation which soon would have blocked the entire lumen of the vein.

SUMMARY

1. Only five cases of varix of the umbilical cord have been reported and in one case the diagnosis was questionable. The number of cases reported probably does not accurately indicate the incidence but suggests the rarity of this type of tumor.
2. Hemorrhage from the rupture of an umbilical varix during the intrauterine environment of the fetus apparently caused no morbidity in the mother since no mention is made in this regard except in the case reported by Adair and myself. In that instance the maternal morbidity may have been due to the absorption of toxic products of fetal decomposition since maceration had begun.
3. Death of the fetus is almost inevitable and is due usually to rupture of the varix wall causing exsanguination but may also result from interference with the blood supply to the fetus by clot formation within the vein.
4. The structure of the clot in the varix showed it to have been of very recent formation,—probably during the last forty-five minutes to one hour of labor when the fetal heart manifested distress of the baby.
5. The life of the baby in this case undoubtedly was spared because of the late formation of the clot which had not as yet completely obliterated the lumen of the vein.

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Dust Studies by United States Public Health Service

Studies by the United States Public Health Service have shown that there is a great difference in the harmfulness of dust. Of those studied, the only dust which had a really serious or fatal effect upon the worker was that containing free silica. In the investigation of granite cutting plants, most of the workers were found to be exposed to an average of about 60 million particles of dust per cubic foot of air. The dust contained about 70 per cent silica, of which about 35 per cent was in the form of quartz or free silica. Under such conditions there was an almost universal occurrence of silicosis, and a large proportion of the workers developed pulmonary tuberculosis. This disease, as a rule, did not make its appearance until after some 20 years of exposure, but when it did develop, a fatal result within less than two years was almost certain.

It used to be thought that the harmful effect of silica dust lay in the sharpness of particles, but now it is believed that some chemical effect is present, associated with the slow dissolving of the free silica particles.

It was not found in this investigation that it would be necessary to eliminate all of the dust to do away with the hazard. A safe limit of somewhere between 9 and 20 million particles of dust per cubic foot of air could be established.

The highest concentrations of dust were found in coal mining, both hard and soft. In these studies there was no great excess of

sickness, but there did appear to be a slowly developing fibrosis which was in a way parallel with the early silicosis found among persons exposed to silica dust, but without the tendency toward tuberculosis.

A large amount of dust was also found in a cement plant. This plant was not typical, but was chosen because a great deal of calcium dust was present. Although no permanently serious effects appeared in this investigation, the workers were subject to a higher frequency of upper minor respiratory diseases and some other conditions.

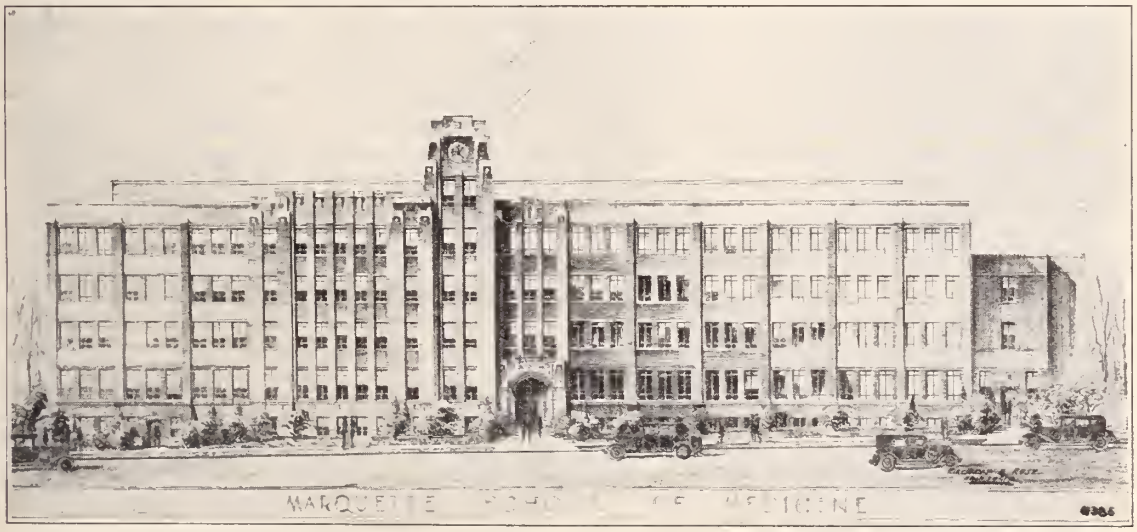
The other studies have added considerable information of a negative nature. In the concentrations found, dust encountered in silver polishing, in a cotton plant, and that to which street-sweepers were exposed, appeared to have no harmful effect upon the workers. In all of these cases the concentrations were relatively low. In the case of street sweepers, however, the air breathed had a higher concentration than that to which the average city dweller is exposed.

The studies in question were not designed to cover all of the dusty trades in this country, but rather to consider specific types of dust. It is known that silicosis and tuberculosis are a serious hazard in certain mining operations, and this question is under continual investigation by the United States Bureau of Mines. The pottery industry, subway construction in granite rock, and many other occupations have a severe silicosis hazard.

The mitigation of the dust hazard in industry is primarily a ventilation problem. In many industries steps have been taken to prevent the escape of dust into the room by surrounding the machine with a suction hood or other device that removes the dust as it forms. This removal of dust at its source is the most important step to be taken.

The important points are the seriousness of the dust hazard, the large number of workers exposed, the varying effect of different dusts, the fact that a certain amount of dust has to be present before a hazard exists, and the necessity for removal of the dust at its source.

New Building of the Marquette University School of Medicine



Marquette University's plan for a unified campus will be brought nearer to realization when construction is started in August on the new building for the school of medicine. The structure will face on N. 15th Street, between W. Wisconsin Avenue and W. Clybourn Street, and is evaluated at approximately $500,000. The new building will be completed and occupied in 1932 and, besides accommodating an increased number of students, will also house at least some of the work of the dental school in the basic sciences. The new school will be another addition to Marquette's prospective health center. The architects are Kirchhoff & Rose of Milwaukee.

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EDITORIALS

BEAUMONT MEMORIAL PROGRESS

NOT BAD!

NOT BAD!!

As a matter of fact, the response to our editorial appeal for contributions to the Beaumont Memorial exceeded the expectations of the writer. Nevertheless, more money is needed to carry out the moderate—not to say modest—plans of the Committee.

Much more than a tribute to the memory of Beaumont is now involved. We are called upon, as a matter of fact, to build a memorial to the appreciation of our own generation of the work of a pioneer Wisconsin doctor. No occasion to be vulgarly ostentatious about it. But as a matter of self respect, neither can we be niggardly about it.

Won't you, right *now*, send in a check for the amount you would contribute if a member of the Committee were to solicit you personally? Obviously, we cannot ask the Committee to vend their wares from door to door. They, too, are busy men—and wouldn't be any too good personal solicitors, in all probability, if they did attempt it. H. E. D.

GOOD VETOES

THANKS to the Governor's veto of a bill enacted by the recent Legislature, we of the medical profession have been saved some irritation and the public from some possible injury. To raise additional revenues the Legislature, within a few hours, passed a bill providing for a charge of 50¢ for each Wassermann and other examination made by the Psychiatric Institute. It was figured that this would raise upwards of $60,000 a year. The Governor wisely held that this measure was inimical to the public health and public welfare because this service is calculated, immediately, to lessen the contagion from venereal disease and, ultimately, the number of insane cared for at public expense. Inasmuch as a considerable number of the patients are indigent, it is held that even a small charge of 50¢ would deter many desirable tests from being made.

The Legislature also passed a bill legalizing the treatment of industrial accidents by chiropractors. Considerable pressure was brought to bear upon the Legislature to pass this measure and, in all probability, to secure Executive approval and signature. All the more credit to the Governor, therefore, for his refusal to be a party to any such effort to exploit injured workingmen, employers and compensation insurance carriers.

THE ANIMAL KINGDOM—A RESERVOIR OF DISEASE*

UNDER the above title, Dr. Karl F. Meyer read a most interesting paper recently. His review of the diseases transmissible from animals to man lists a really formidable array. As our knowledge of medicine in all

* Proc. Inst. Med. Chicago, 8: 234. 1931 (May–June).

its branches grows, we are brought more and more face to face with the fact that the interrelationships of animals and man is a close one.

Although there were occasional references in Greek medical writings which may be looked upon as suggestions that animals transmitted diseases to man, and Fracastoro in 1546 definitely stated that the bite of a mad dog produced disease, the knowledge of the transmissibility of disease from animals to man was scarcely considered. One can set a definite date for the beginnings of the study, 1796, when Jenner proved that cowpox could be transmitted to man. Since then our knowledge has accumulated by leaps and bounds.

Some of the members of the animal kingdom introduce poisonous substances to man by bites, by hairs, by special spines, except in the cases of bites by scorpions and snakes the resulting contact is only disagreeable, as for example, contact with jellyfish.

Meyer calls attention to the curious fact that the poison of snakes is primarily a substance aiding in the digestion of food and not, as popularly supposed, a substance primarily for aggressive combat or for defense. If snake venom is gathered soon after a meal, the venom is no longer a poison, and further, the reptile is apt to die. "The shedding of the skin, accompanied by profound general metabolic disturbances, requires the retention of the venomous secretion of the special gland." In bees and wasps there is evidence that the secretion of the stinging gland is connected primarily with the sex function. Only females have the stinging power. "The venom is fixed on the eggs and thus aids in their development."

There is the story of two children who died from eating bear meat. It was found that the bear had frequented a hog pen and its meat was full of trichinella spiralis.

We have long recognized the danger from flies and from the bites of mosquitoes. Bedbugs, lice, fleas, ticks are known to carry diseases often proving fatal. In California the ground squirrel has been found infected with bacilli of bubonic plague, a disease which is transmitted by flea bites. The relationship between the bite of the wood tick and Rocky Mountain spotted fever has been carefully worked out. This disease has a fearful mortality. Tularemia from rabbits, undulant fever from cattle are two diseases which have only recently been worked out.

All are familiar with the transmission of malaria and yellow fever by mosquitoes. In the tropics other diseases are transmitted by flies and mosquitoes such as "sleeping sickness" (filarial) and verruca peruviana or Oroya fever.

There is a fascinating story told by Meyer of the epidemics of poisoning caused by mollusks. It seems that shellfish only are poisonous at a certain time of the year, roughly from July 8th to August 22nd. This corresponds roughly to the spawning season, although the two phenomena do not run strictly parallel. It is a very curious fact that poisonous substances are developed in so many animals during the season when egg-laying takes place. Often the eggs are highly poisonous. The substances poisonous for human beings and other animal forms seem to have a very close connection with the sexual life of the animal.

As doctors, we need not be expert veterinarians but we do need to have considerable knowledge of the animal vectors of disease. We are constantly running into human diseases which are transmitted by animals. Sometimes the diseases are modified animal diseases, sometimes the animals act only as transmitters from one human to another, sometimes animals act as intermediary hosts in the complicated life cycles of disease-producing organisms.

The subject is a fascinating one aside from its immense practical importance. Rightly has Dr. Meyer called his address "The Animal Kingdom—A Reservoir of Disease".

L. M. W.

BASIC SCIENCE BOARD MEETS

The next examinations by the Wisconsin State Board of Examiners in the Basic Sciences will be held at Hotel Loraine, Madison, on September 19th. Applications should be addressed to the Secretary, Prof. Robert N. Bauer, 3414 West Wisconsin Avenue, Milwaukee.

THE PRESIDENT'S PAGE

C. A. Harper

HOSPITALS

THIS is the age of hospitals and hospitalization, therefore a pertinent subject for consideration, especially when the economic factor, coupled with reasonable efficiency, is a matter of general concern.

Apparently the Bellevue Hospital in the city of New York, begun in 1658, initiated the hospital program. This was followed by the Blockley Hospital, Philadelphia, in 1731 or after a period of 73 years. The first hospital operated by the federal government, 1798, was known as the Marine Hospital, located at Washington Point, Norfolk. This cost the government $1,800 and was created for the purpose of taking care of the seamen in the marine service. An act of July 16, 1798, provided that after September 1, 1798, the master of every American ship arriving from a foreign port should pay to the Collector of Customs the sum of twenty cents a month for each seaman. On this basis within the next few years a number of hospitals for the merchant seamen were erected in different sections of the country. Secretary of State Chase in 1861 stated that "the marine hospitals have been increased far beyond the necessity or utility." In March, 1862, an act was passed authorizing the Secretary of the Treasury to rent marine hospitals to authorities of cities.

The question arises whether the trend toward hospital construction is not beyond the reasonable necessities of the situation, and whether the hospitals are becoming in part monumental structures instead of being of an architectural type that would reasonably meet the demands of the community. The variation in cost per bed appears to be wholly out of proportion to the accommodations essential in providing proper care for the sick. Two hospitals recently completed, one in Wisconsin and the other in a large city outside of this state, differed in cost of $4,800 per bed. One, the Wisconsin hospital, records a cost of something like $2,400 per bed while the hospital in the larger city cost $7,200 per bed.

The economies of the situation may well question the justification of this variation. There is no question but that the cost of hospitalization forms a large basis for the considerations that are now going on pertaining to the cost of medical care as a whole. Some phases of this undoubtedly should concern the medical profession.

It is generally agreed that hospitals should be constructed and equipped to render at all times most up-to-date, scientific hospital care. Beyond this, great caution should be exercised to hold within reasonable bounds the initial cost of the structure. Otherwise it is self-evident that unnecessary hardships occasionally, if not frequently, will be placed upon those needing hospital care in order to meet an overhead that is not primarily essential to the great mass of patients who of necessity must receive hospital service.

A community, in planning for a hospital, should take into consideration the ability of the citizenship of the community in which the hospital is supposed to serve, and construct its hospital on a comparative basis of the community's ability to pay rather than on the comparative merits of a hospital in a large and wealthy community where certain accessories may be permissible and yet not fundamentally essential to the needs of a well-organized hospital. It would appear wiser indeed, not only during the period of economic distress but at all times, that society would profit more by limiting to a marked degree all unnecessary cost pertaining to the structure of a hospital beyond the essential and reasonable necessities and have the personnel essential to a properly conducted hospital receive adequate compensation for their services, and obtain equipment that is up-to-date, standardized, and essential to all well-conducted hospitals. As far as the proper care of the sick is concerned, it would appear that scientific hospital equipment is far more essential to the welfare of the patients therein than is the monumental structure itself which is found to go beyond the reasonable essentials to an efficient hospital as an institution.

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Green Lake-Waushara-Adams	J. M. Johnson, Ripon	A. J. Wiesender, Berlin.
Iowa	T. A. Hagerup, Dodgeville	H. M. Walker, Dodgeville.
Jefferson	Will Young, Ft. Atkinson	M. G. Peterson, Lake Mills.
Juneau	C. A. Vogel, Elroy	A. T. Gregory, Mauston.
Kenosha	W. H. Bennett, Kenosha	W. H. Lipman, Kenosha.
La Crosse	W. J. Jones, La Crosse	R. L. Eagan, La Crosse.
Lafayette	R. B. Quinn, Darlington	W. B. Williams, Argyle.
Langlade	E. J. Donohue, Antigo	J. C. Wright, Antigo.
Lincoln	F. L. Kelley, Merrill	W. H. Bayer, Merrill.
Manitowoc	W. G. Kemper, Manitowoc	C. H. Barnstein, Newton.
Marathon	Joseph F. Smith, Wausau	Verne E. Eastman, Wausau.
Marinette-Florence	T. J. Redelings, Marinette	M. D. Bird, Marinette.
Milwaukee	E. L. Tharinger, Milwaukee	Theo. Wiprud, Ex. Sec'y, Milw.
Monroe	A. E. Winter, Tomah	H. H. Williams, Sparta.
Oconto	R. J. Goggins, Oconto Falls	G. W. Krahn, Oconto Falls.
Oneida-Forest-Vilas	C. D. Packard, Rhinelander	I. E. Schiek, Rhinelander.
Outagamie	J. L. Benton, Appleton	R. V. Landis, Appleton.
Pierce-St. Croix	J. H. Armstrong, New Richmond	A. E. McMahon, Glenwood City.
Polk	L. O. Simenstad, Osceola	Geo. B. Larson, Frederic
Portage	F. A. Marrs, Stevens Point	H. P. Benn, Stevens Point.
Price-Taylor	F. W. Mitchell, Medford	G. E. MacKinnon, Prentice.
Racine	J. F. Bennett, Burlington	Susan Jones, Racine.
Richland	Bertha Reynolds, Lone Rock	G. Benson, Richland Center.
Rock	H. E. Burger, Beloit	E. C. Hartman, Janesville.
Sauk	Roger Cahoon, Baraboo	A. C. Edwards, Baraboo.
Shawano	C. E. Stubenvoll, Shawano	L. W. Peterson, Shawano.
Sheboygan	John Hansen, Glenbeulah	A. C. Radloff, Plymouth.
Trempealeau-Jackson-Buffalo	J. W. Lowe, Merrillan	R. L. MacCornack, Whitehall.
Vernon	W. M. Trowbridge, Viroqua	Wm. H. Remer, Chaseburg.
Walworth	E. J. Fucik, Williams Bay	S. G. Meany, East Troy.
Washington-Ozaukee	N. E. Hausmann, Kewaskum	P. M. Kauth, Slinger.
Waukesha	F. J. Donnelly, North Lake	J. F. Wilkinson, Oconomowoc.
Waupaca	R. K. Irvine, Manawa	F. J. Pfeifer, New London
Winnebago	G. V. Lynch, Oshkosh	M. C. Haines, Oshkosh.
Wood	F. X. Pomainville, Wisconsin Rapids	W. G. Sexton. Marshfield.

SOCIETY PROCEEDINGS

CALUMET

Dr. F. P. Knauf of Kiel addressed a joint meeting of the Calumet County Medical Society and the Chilton Kiwanis Club at Hotel Chilton on June 16th. His subject was "Your Health."

CLARK

On July 2nd the Clark County Medical Society held its annual meeting in the community room of the Citizens State Bank building at Loyal. The following doctors were admitted to the Society: Dr. Sarah D. Rosekrans, Neillsville; Dr. Milton Rosekrans, Neillsville; Dr. F. J. Diamond, Loyal; Dr. Gilardte, Greenwood and Dr. R. Jandrain, Abbotsford.

After an enthusiastic discussion by the members present, as to the rejuvenating of the Clark County Medical Society, it was decided to hold another meeting the last week in July at Owen. Golf will be played at the Owen Country Club in the afternoon with dinner and a scientific program at the Woodland Hotel in the evening.

New officers for the ensuing year were elected as follows: President, Dr. R. R. Rath, Granton; Secretary-treasurer, Dr. A. L. Schemmer, Colby; Delegate, Dr. H. H. Christofferson, Colby; Alternate, Dr. R. H. Wink, Granton. A. L. S.

GREEN

The members of the Green County Medical Society met at the Hotel Ludlow, Monroe, on Thursday evening, June 18th. Following a 6:45 o'clock dinner served at the hotel, members of the Society had the pleasure of listening to the following program:

1. "Spinal Anesthesia" with moving picture by Dr. Arnold Jackson, Madison.
2. "Habitual Dislocation of the Shoulder" with moving picture by Dr. J. A. Jackson, Madison.
3. "Treatment of Burns" by Dr. C. Kenneth Cook, Madison.

At the close of the program the following officers were elected for the ensuing year: President, Dr. W. B. Gnagi, Sr., Monroe; Vice-President, Dr. L. A. Moore, Monroe; Secretary-treasurer, Dr. J. F. Mauermann, Monroe. J. F. M.

MILWAUKEE COUNTY PICNIC

The Medical Society of Milwaukee County held its second annual picnic at Golden Lake on June 20th. A good crowd was on hand to enjoy the varied program planned by the social committee, whose members are: Drs. James C. Sargent, chairman, J. F. Shimpa, H. O. Zurheide, Oscar Lotz, S. M. Mollinger, Roland S. Frederick.

Mrs. E. L. Tharinger, wife of the President of the Society, was hostess of the day, and the ladies entertainment was in charge of Dr. Eleänore Cushing-Lippitt. Dr. Joseph C. Griffith was the winner of the golf contest; and prizes were given to the children who won the games and contests planned especially for them. There were many games, water sports, a baseball game, horseback riding for the children. Everyone present reported a good time. T. W.

POLK

The Polk County Medical Society held its regular monthly meeting on Thursday evening, June 25th, at St. Croix Falls as the guest of Dr. J. A. Riegal. A barbecue dinner was served at six-thirty.

The medical topic for the evening was given by Dr. T. L. Birnberg of St. Paul. Dr. Birnberg gave a brief review of the recent pediatric conference held at Stockholm. At the close of the regular meeting, Dr. Birnberg gave a talk with moving pictures on present-day Russia. G. B. L.

RACINE COUNTY PICNIC

The annual picnic of the Racine County Medical Society was held on June 24th in Old Settlers Park near Union Grove. With the exception of two minor casualties, the picnic was reported one of the most successful ever held. Dr. Harry G. Walters, Racine, was incapacitated following a strenuous foot race, and Dr. George H. Jamieson, Racine, twisted an ankle in a similar contest.

Following the athletic contests, a picnic supper was served at Hotel Shephard. A baseball game between the North Siders and the South Siders was won by the former with a score of 22 to 11. Dr. Robert Thackeray was in the pitcher's box for the winning team and Dr. Andrew S. Pfeiffer for the South Siders.

The picnic was in charge of a committee composed of Drs. C. O. Schaefer, John Docter, Paul R. Hahn, R. D. Jamieson and E. C. Pfeifer.

Mrs. Carl Schaefer won the balloon bursting contest and Mrs. R. D. Jamieson was declared winner in the necktie tying contest.

TREMPEALEAU–JACKSON–BUFFALO

A meeting of the Trempealeau–Jackson–Buffalo County Medical Society was held on June 4th at Merrillan.

Dr. W. D. Stovall, Madison, gave a talk on "Laboratory Methods and Clinical Diagnosis." Dr. R. C. Buerki, Madison, spoke briefly of the work in medical extension of the University. Miss Marguerite Lison outlined the recent survey of crippled

children in Trempealeau County. Dr. F. J. Gaenslen, Milwaukee, was chosen by the Society to conduct this clinic held at Whitehall on Tuesday, June 30th. The Society held its monthly meeting in conjunction with the orthopedic clinic. R. L. M.

VERNON

A meeting of the Vernon County Medical Society was held on June 24th at the Farmers' Bank, Viroqua.

Because the speaker scheduled to address the group was unable to attend, a round table discussion of various topics of interest to all was had. It was the opinion of all present that it was one of the most interesting meetings held for a long time. W. H. R.

WOOD

A meeting of the Wood County Medical Society was held in St. Joseph's Hospital, Marshfield, June 25th. The meeting was preceded by a dinner at the Hotel Charles at six-thirty o'clock.

Papers were presented as follows:

1. "Complications of Middle Ear Infections" by Dr. L. A. Copps, Marshfield.
2. "Some Aspects of Acute Rheumatic Fever" by Dr. K. H. Doege, Marshfield.
3. "Recent Advances in Clinical Obstetrics and Gynecology" by Dr. John W. Harris, University of Wisconsin, Madison.

FOURTH DISTRICT

The sixth annual meeting of the Fourth Councilor District was held on June 18th at the Grantland Club Rooms, Lancaster. Dr. J. C. Doolittle, Lancaster, presided at the meeting.

The scientific program which began at two o'clock consisted of the following:

"Some Phases of Socialized Medicine" by Dr. C. A. Harper, President of the State Medical Society.

"Diagnosis and Treatment of Surgical Lesions of the Biliary Tract and Liver" by Dr. Reginald H. Jackson, Madison. This paper was illustrated with gall bladder study slides by Dr. J. Newton Sisk, Madison.

"Simple Methods of Managing Diabetic Patients" by Dr. E. L. Sevringhaus, Madison. Miss Leonore Healy, state dietitian, assisted in the demonstration.

"Management of Breech Presentations"—motion pictures by Dr. Joseph B. DeLee, presented by Dr. M. Edward Davis, Chicago.

Following the program, the members were guests of the Lancaster Kiwanis club at dinner.

FIFTH DISTRICT

The annual meeting of the Fifth Councilor District was held at Pine Point Hotel on beautiful Elkhart Lake on Thursday, June 25th. A goodly number of doctors and their wives from this and neighboring districts attended both the afternoon and evening meetings.

While the ladies played bridge, the doctors enjoyed the following program:

"Some Remarks on Functional Contrasted with Organic Abdominal Disturbances" by Dr. T. L. Szlapka, Milwaukee.

"The Clinical Interpretations of Cerebrospinal Fluid" by Dr. W. F. Lorenz, Madison.

"Medical Testimony" by Mr. F. M. Wilcox, chairman of the Industrial Commission, Madison.

"Appendicitis" by Dr. Nelson M. Percy, Chicago.

"Acute Intestinal Obstruction" by Dr. C. F. Dixon, Rochester.

Following the dinner, during which Miss Doris Dietsch of Plymouth delighted the audience with her wonderful voice and Buddy Fisher's famous orchestra furnished music and entertainment, Dr. C. A. Harper, President of the State Medical Society, gave an enlightening talk on "Some Phases of Socialized Medicine."

This was followed by an illustrated lecture on "Pink Pills for Pale People" by Dr. Arthur J. Cramp, director of the Bureau of Investigation of the American Medical Association.

Dr. C. L. MacCollum, Manitowoc, as President of the fifth district, presided at both the afternoon and evening meetings. All credit is due to our councilor, Dr. A. H. Heidner, West Bend, for arranging an interesting program and a worthwhile and successful meeting. Officers elected for the coming year are: President, Dr. Fred Knauf, Kiel; secretary, Dr. Alfred C. Radloff, Plymouth.

A. C. R.

NINTH DISTRICT

The summer meeting of the Ninth Councilor District Medical Society was held at Wisconsin Rapids on the evening of July 15th. Dinner was served at the Hotel Witter at six-thirty o'clock, followed by the regular program:

"Nephritis in Children" by Dr. R. H. Juers, Marshfield.

"The Diagnosis and Treatment of Cardiovascular Diseases" by Dr. Francis D. Murphy, Milwaukee.

LOBBY EXPENSES FILED

Chiropractors through the Wisconsin Chiropractic Association expended $1658 in lobby effort during the 1931 Legislative session according to reports filed July 27th, with the Secretary of State. Of this total, $1100 was paid in salary to former Assemblyman Henry A. Staab of Milwaukee who acted as their representative.

The state Medical Society filed expenses of $1007, largely for the mailing of occasional informative bulletins to the members. The Wisconsin Osteopathic Association spent $500; the Homeopathic Society $100 and the Eclectic Society $10, all on Bill 345A which would have changed the composition of the Board of Medical Examiners as proposed by the Medical Society.

NEWS ITEMS AND PERSONALS

At the annual meeting of the stockholders of the Algoma hospital, Dr. H. V. Foshion, Algoma, was re-elected president of the institution.

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Dr. W. W. Bauer, health commissioner for Racine, addressed a meeting of the League of Wisconsin Municipalities at Marshfield on June 18th. Dr. Bauer spoke on public health work.

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More deaths from cancer occurred in Madison in 1930 than in any other city of the United States, in proportion to population, according to an article by Frederick L. Hoffman, consulting statistician, in a recent issue of The Spectator, an insurance publication.

Madison's total of deaths from that cause in 1930 was 135, which is equivalent to 231.7 deaths per 100,000 population. Mr. Hoffman's article points out, however, that Madison's high cancer death rate is due in part to the large number of outside cases brought to the hospitals there.

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Dr. R. L. Cowles, Green Bay, spoke on "Immunity" before a meeting of the Green Bay Rotary Club at the Beaumont Hotel.

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Dr. John Tasche, Jr., son of Dr. and Mrs. John Tasche, 521 Huron Avenue, Sheboygan, Wisconsin, who graduated from the College of Medicine, University of Cincinnati, Ohio, on June 13th, has been honored with an appointment to the Surgical Staff of the Frauen Klinik in Munich, Germany. The appointment is for twelve months, and began on July 15, 1931.

Dr. Tasche will be under the direct tutelage of Professor Hans Soenger, Director of the Department of Gynecology, Universitats Klinik fur Frauen Krankheiten, Munich, Germany. Professor Soenger is an internationally prominent gynecological surgeon, and widely quoted authority on diseases of women.

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Dr. H. C. Werner, superintendent of Wisconsin Memorial hospital, Madison, was speaker at a meeting of the Kiwanis Club in the Park Hotel. Dr. Werner discussed the mental rehabilitation of the ex-service man.

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Dr. M. J. J. Coluccy, Madison, was elected delegate to the state convention of the Forty and Eight Society to be held in Chippewa Falls in August.

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Dr. F. O. Zillessen, formerly pathologist at St. Agnes' Hospital, Fond du Lac, left the latter part of June for Easton, Pa., to become pathologist at Easton City hospital.

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Dr. C. J. Combs of Oshkosh spoke on state medicine at a meeting of the Lions Club of Oshkosh in the Hotel Athearn.

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At the annual convention of the National Association of Master Plumbers, Dr. C. A. Harper, state health officer, was one of the principal speakers. In his talk, Dr. Harper stressed the importance of the plumbing code in the health of the state.

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Dr. E. L. Sevringhaus, Madison, addressed the women's convocation at the annual Farm Field Day held at the University of Wisconsin, in July on the subject of "Diabetes, Obesity and Undernutrition."

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Dr. P. M. Kauth of Slinger returned the latter part of June from a month's visit in the East.

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Dr. S. M. Welsh, formerly with the Children's Memorial hospital at Chicago, and who previous to that time served his internship at St. Francis Hospital, La Crosse, is now associated with Drs. Evans, Bannen, McGarty and Evans, La Crosse. Dr. Welsh will specialize in obstetrics and infants and children's diseases.

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Dr. George N. Pratt, Neenah, was speaker at a meeting of the Kiddies Safety Club of the Menasha Kiwanis club. He talked on burns from fireworks.

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Dr. F. B. Farnsworth of Janesville received minor bruises on July 2nd when the car which he was driving tipped over after he had lost control of the car following a tire blow-out.

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Dr. A. J. Pullen of Fond du Lac delivered an address on "Sunstroke" before a meeting of the Kiwanis Club of Fond du Lac on June 30th.

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Dr. Carl W. Bradford, his sister, and Mrs. Byrd Crowell of Hudson sailed on July 18th from Montreal for Europe. They will travel through Holland, Germany, England, Austria, France, Belgium and Switzerland. In Switzerland, Dr. Bradford will attend the International Neurological Congress. They plan to return the latter part of September.

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On August first, Dr. H. H. Reese, associate professor of neuropsychiatry, University of Wisconsin Medical School, sailed for Europe on the S. S. Kungsholm to attend the International Neurological Congress at Berne, Switzerland, August 1st to Septem-

ber 4th. Dr. Reese will give a paper on "Tryparsamide", giving his experiences with this drug over a period of ten years.

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Dr. S. A. Freitag, who has just completed 43 months' training in urology and skin diseases, has been chosen as a member of the Pember-Nuzum Clinic, Janesville, to succeed the late Dr. Gerald K. Wooll.

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Dr. De Witt Beebe, son of Dr. Spencer D. Beebe of Sparta, and who recently completed internship at New Orleans Charity Hospital, is now a member of the Sparta Clinic composed of his father, his uncle, Dr. Carlton Beebe, his cousin, Dr. Chauncey Beebe, and Dr. Hugh H. Williams.

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Dr. Gideon Benson, Richland Center, was reelected president of the school board for his 13th consecutive term.

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Dr. Arthur Cantwell, who recently completed internship in Chicago, has joined the Cantwell-Peterson Clinic in Shawano. He will specialize in obstetrics and gynecology.

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Dr. John Docter of Racine has been named as the Racine County Medical Society's representative in the mayor's advisory council according to an announcement on July third.

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Dr. B. I. Pippin of Richland Center, and Dr. H. A. Shearer of Beloit left on July 15, for Denver, Colorado, where they will attend a summer session of the Whitaker eye clinic, returning August first. They made the trip in Doctor Pippin's airplane.

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MILWAUKEE

At the weekly luncheon of the Shrine Booster Club, held at the Athletic Club on June 12th, Dr. W. J. Carson gave an illustrated talk on "What a Man Should Do At 50."

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Mrs. Florence Killilea Boley, wife of Dr. Michael H. Boley, died Monday, June 15th, at the Milwaukee General Hospital, after an illness of about two weeks. Mrs. Boley was widely known through her connection with the Milwaukee Baseball Club, of which she was president, succeeding her father, who was president of the Club prior to his death in 1929.

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Dr. J. L. Yates presented a paper, "Vital Capacity," at a staff meeting of the Muirdale Sanatorium, June 16th.

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Dr. and Mrs. C. A. Evans have gone to their summer home at Fish Creek, in Door County, for the summer months.

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Dr. and Mrs. W. F. Grotjan recently enjoyed a vacation in Minneapolis.

Dr. Eben J. Carey has been awarded a citation of merit by the American Medical Association for his exhibit on curvature of the spine at the recent convention of the Association at Philadelphia.

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Drs. C. A. Harper, of the State Board of Health, and J. P. Koehler, Milwaukee Health Commissioner, spoke over Radio Station WTMJ during Public Sanitation Week—June 22–27th.

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At the mid-year Sanatorium conference held at Lakeview Sanatorium, Madison, June 20th, the following Milwaukee physicians participated:

Dr. Hoyt E. Dearholt, executive secretary of the W. A. T. A., presided at the general session in the morning;

Dr. Florence MacInnis, of the W. A. T. A. medical staff, spoke on "The Tuberculin Test";

Dr. A. A. Pleyte, of the W. A. T. A. medical staff, gave an address on "Value and Technic of X-Ray in the Care of the Tuberculous Sick";

Dr. A. L. Banyai, clinical director of Muirdale Sanatorium, and Mr. William L. Coffey, manager of the Milwaukee County Institutions, also appeared on the program.

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Dr. J. P. Koehler, Milwaukee Health Commissioner, has announced a reorganization of the health department, soon to take place. Several divisions with overlapping jurisdictions, which have been acting independently, will be grouped under one head, —the medical bureau. Such a move, it is believed, will make for better co-ordination and greater economy. The divisions of school hygiene, school doctors and nurses, tuberculosis, clinic, contagious diseases, school and pre-school clinics are to be grouped with the medical service bureau. By grouping these divisions authorities will be centralized under one bureau director, and a closer supervision over contagious diseases and physical ailments of school children will be possible. Plans for the consolidation will be completed by fall.

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Rev. William M. Magee, S. J., President of Marquette University, has announced that work on a new $500,000 building for the Marquette University School of Medicine will begin late in August. The new building will be located between the Marquette Dental School and the University Gymnasium. The new building will be similar to the other Marquette structures,—in Gothic design,—of reinforced concrete construction, walled with orange-buff brick, and will be four and one-half stories in height. Plans for the medical addition have been under way for more than five years, and the program calls for the latest features in medical-school design and equipment. The new building will have a capacity of 375 students, less than a hundred more than could be accommodated in the present medical school, but the number is purposely limited in order to keep within its rating as a Class A school. Unusual facilities

will be offered for private laboratory research by faculty members and graduates. It is expected that the new structure will be completed by March, 1932, but occupancy will undoubtedly be delayed until the fall of that year.

"Marquette has far-reaching plans for its new unit", said both Rev. Anthony Berens, S. J. Regent, and Dr. Bernard F. McGrath, Dean of the Medical School. "These structures, along with the dental building and gymnasium will see our dream of a health center come true. With this up-to-date building and the excellent clinical facilities offered in a city as large as Milwaukee, Marquette is in the first rank of medical schools".

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Mrs. Byron O. Nobles, wife of Dr. Byron O. Nobles, died at her home, 1303 W. Washington Blvd., on June 11th, at the age of 58 years. Mrs. Nobles is survived by her husband, a daughter, Miss Beulah Nobles, a son, Forrest, and one grandson, Zoa Gail Nobles.

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Dr. J. P. Koehler, Milwaukee Health Commissioner, has accepted an invitation to serve as adviser in health and sanitation at the Y. M. C. A. Camp Minikani on Lake Amy Belle. The summer season of the camp opened the latter part of June.

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Dr. Elisabeth Seiler has left for Germany where she expects to visit her parents for the summer months.

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Dr. and Mrs. Arthur T. Holbrook and Dr. and Mrs. Harold Holbrook spent several weeks in Brule, Wisconsin, on vacation.

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Dr. Thomas F. Furlong, Jr., of Philadelphia, spent the month of July in Milwaukee visiting his mother, Mrs. J. W. Furlong.

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Dr. and Mrs. A. H. Cohn and family are spending the summer at Conover, Wisconsin.

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Dr. John E. Guy was elected President of the Wisconsin State Board of Medical Examiners at a meeting of the Board on July 2. Dr. Robert E. Flynn of LaCrosse was re-elected secretary. Committees were named as follows:

Legislative: Drs. Wilbur N. Linn, Oshkosh; Royal Rodecker, Mercer; J. Gurney Taylor, Milwaukee.

Examinations: Drs. T. J. Sheehy, Tomah; E. C. Murphy, Eau Claire; Wilbur N. Linn, Oshkosh.

Reciprocity: Drs. J. B. Brewer, Jefferson; J. Gurney Taylor, Milwaukee; Wilbur N. Linn, Oshkosh.

Mid-wifery: Drs. J. B. Brewer, Jefferson; Royal Rodecker, Mercer.

Massage and Chiropody: Drs. E. C. Murphy, Eau Claire; T. J. Sheehy, Tomah.

The Board met in Milwaukee in connection with the holding of its annual examinations for medical students. A total of 94 students took written and practical tests for three days.

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The plan sponosored by the Medical Society of Milwaukee County to have the Milwaukee County indigents cared for by the family physician,—under certain restrictions,—was given consideration by the committee on county institutions on July 7th. If the Society's plan is accepted, the present district-physician system will be abolished. Appearing for the Society were Dr. E. L. Tharinger, president; Dr. P. M. Currer, president-elect; Dr. H. J. Gramling, chairman of the public health advisory committee; Dr. Ralph P. Sproule, chairman of the health council; Mr. Gregory Gramling, attorney for the Society, and Mr. Theodore Wiprud, executive secretary.

After considerable discussion action on the Society's plan was deferred to give the committee ample time to study the proposal.

In commenting upon the Society's plan, The Milwaukee Medical Times in an editorial had the following to say:

"Of one thing the medical profession is absolutely sure, and that is that the proposed system would prove beneficial to the patient. No matter how diligent a physician may be in his official capacity, his attitude toward his patients is necessarily different than in private practice. Under the system existing in Milwaukee County at the present time, each district physician, acting in his official capacity, is responsible for certain sections of the city. His compensation not being enough to warrant his giving full-time to this work, he must, in addition, carry on his own private practice. It is natural that his private practice should receive first consideration. This is not a reflection on those who are serving, but a natural result of the present system.

"Under a system of free selection of physicians the situation would be entirely different. The relationship between the indigent and the physician would be of a personal nature which is so important in successfully treating the sick. The physician would, in this closer relationship and under the usual conditions of private practice, bring to his patients service equal to that given to those in his own private practice.

"In its proposals for a general medical service for England, the British Medical Association urges a contributory insurance system for all classes. Among the reasons advanced for the adoption of such a system are the following: 'Such a system more than any other tends to preserve self-reliance and independence and to promote thrift', and that it tends 'to maintain and to develop some of the most valuable features of private practice,—for example, *as full a choice of doctor by patient as possible.*' It is further stated, 'The desire of even

poor people to provide for themselves is a deeply-rooted and laudable instinct which should always be encouraged. The need for an aided insurance system applies especially to the dependents of the present insured class. They could, with some help from the state, make provision not only for a family doctor, but for those other non-institutional services which are necessary to supplement the family doctor.' "

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The Health Council met with Dr. J. P. Koehler, Milwaukee Health Commissioner, at the City Club on June 23rd, to discuss with Dr. Koehler the proposed ordinance for the examination of food handlers.

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An intensive campaign to eradicate diphtheria is planned for the month of August. This is the second joint compaign sponsored by the Medical Society of Milwaukee County and the Health Department, and the Society believes that if each member will urge the immunization of children under his care that much good will be accomplished, and the campaign will prove successful.

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A communication from the Wisconsin Telephone Company, dated June 1, directed to the Physicians' Service Bureau, advised that in the future all emergency calls received by them for physicians would be relayed directly to the Bureau.

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The Health Council at its last meeting on June 23, concluded to establish a Bureau of Blood Donors. Dr. E. L. Tharinger, president of The Medical Society of Milwaukee County, was requested to work out detailed plans for this Bureau and submit them at the next meeting of the council.

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Dr. W. L. Herner has been appointed medical director of the Sacred Heart Sanitarium.

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Dr. E. L. Miloslavich, director of the department of clinical pathology and medical research at St. Mary's Hospital, Milwaukee, spoke on "Pathology in Relation to Criminology" at the joint meeting of the Kiwanis, Lions and Rotary Clubs at Wausau, on February 23. The doctor also delivered an address on "Our Present Day Crime Problems at the meeting of the Rotary Club at Menomonee Falls, on March 4, and to the Knights of Columbus at Milwaukee on March 17.

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Dr. William L. Herner recently was appointed medical director of the Sacred Heart Sanitarium to succeed Dr. Stephen S. Stack who has resigned.

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The Medical Society of Milwaukee County and the Milwaukee Health Department are cooperating in a joint campaign during the month of August to eradicate diphtheria. All Society members are urged to participate actively and to urge parents to bring their children to them for immunization. The Health Department has established forty-five stations where physicians may obtain toxoid or toxin-antitoxin without charge.

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Mr. Mac Cahal, the newly appointed executive secretary of the Sedgwick County Medical Society, Wichita, Kansas, was a Milwaukee visitor in July. Mr. Cahal came to Milwaukee at the suggestion of the American Medical Association which informed him that he would find the Milwaukee Society as far advanced in its relations with the public as any in the country.

The Wichita organization is composed of 165 active members, and is the smallest medical organization employing a full-time man. The doctors of Wichita are planning a physicians' service bureau patterned after the Bureau owned by the Medical Society of Milwaukee County.

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Dr. Frank L. Rector, field representative of the American Society for the Control of Cancer, of New York, visited Milwaukee during July for the purpose of making a survey of facilities for the treatment of cancer.

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Dr. Nelson M. Black of Miami, Florida, formerly of Milwaukee, has arrived in Milwaukee to spend the remainder of the summer.

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Dr. Eleänore Cushing-Lippitt represented the Women's Alliance of the First Unitarian Church of Milwaukee at the Annual Conference of the General Alliance of Unitarian Women at the Isle of Shoals, off Portsmouth, N. H. Following the conference Dr. Cushing-Lippitt and her husband, Dr. S. Herman Lippitt, toured Nova Scotia and New Brunswick.

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At the last meeting of the Board of Directors of the Medical Society of Milwaukee County it was agreed that an invitation be extended to the American Medical Association to hold its 1933 meeting in Milwaukee.

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A special committee has been created to consider with Mr. W. L. Coffey, Manager of the Milwaukee County Institutions and the Board of Trustees of the County Institutions the proposed plan of The Medical Society of Milwaukee County for the care of the indigent. The following physicians have been appointed by Dr. Tharinger, President of the Society, to form this special committee:

Dr. W. J. Grotjan, Chairman, Dr. Dexter Witte, Dr. W. L. MacKedon, Dr. R. E. Fitzgerald, Dr. Gilbert E. Seaman.

If the Society's plan for the care of the indigent is accepted, the present district-physician system will be abolished and the indigent cared for by their own family physician.

—△—

Ground has been broken for a $190,000 addition to Columbia Hospital. The new addition will con-

tain 65 beds, living quarters for 12 doctors, waiting rooms, utility rooms, and special orthopedic treatment rooms. It is expected that it will be ready for use some time in November.

—△—

The Milwaukee Hospital addition, costing $375,000, will be completed and ready for use by the first of the year, 1932. Administration offices, outpatient department and improved service facilities will occupy the first floor; three floors will be given over to rooms for patients, including a children's department, while the fourth floor will be devoted to operating service which will include the most modern ideas in that line.

—△—

Dr. L. A. Schuenzel spent a two weeks' vacation in the northern part of Wisconsin.

—△—

Dr. J. P. Koehler, Milwaukee health commissioner, has announced a steady improvement in the general health of Milwaukee for the first six months of 1931 as compared with the same period in 1930. Dr. Koehler attributes the noticeable improvement in health standards to the fact that the depression has compelled many persons to live at a slower pace than they have been accustomed to in the past ten years.

—△—

Dr. R. E. Hickey, superintendent of the Contagious Disease Bureau has hit upon a plan of bringing the clinics to the children, instead of the usual order of having the children taken to the clinics, as a means of furthering the campaign to immunize Milwaukee pre-school and school children against diphtheria. Dr. Hickey expects to hold clinics in two churches near Red Arrow Park, a popular playground for children, where free treatment will be administered to all children who apply. If Dr. Hickey can secure permission from the park board he plans to establish a station in Washington Park where thousands of children play every day. If these two experiments prove successful, he plans to set up other clinics in larger city parks and near public playgrounds.

BIRTHS

A daughter to Dr. and Mrs. Wm. M. Jermain, Milwaukee, May 30th.

A daughter to Dr. and Mrs. Mark Bach, Milwaukee, May 29th.

A son to Dr. and Mrs. B. J. Baumle, Milwaukee, June 18th.

A daughter to Dr. and Mrs. Karl Kassowitz, Milwaukee, May 31st.

A daughter to Dr. and Mrs. E. C. Bach, Milwaukee, June 26th.

A son to Dr. and Mrs. R. M. Wheeler, Madison, June 29th.

MARRIAGES

Dr. Frank E. Drew, Milwaukee, to Miss Gertrude Fellman, daughter of Dr. George H. Fellman, Milwaukee, June 27th.

Dr. Harold W. Hein, Milwaukee, to Miss Florence E. Smith, daughter of Dr. and Mrs. S. M. Smith, Milwaukee, June 16th.

Dr. E. L. Watson, Madison, to Miss Mildred Reynolds, Shorewood, Milwaukee, July 3rd.

DEATHS

Dr. P. J. Noer, Wabeno, died of cerebral hemorrhage on June 26th.

He was a graduate of the University of Wisconsin in 1887; the University of Michigan School of Medicine in 1892. He had been in practice for thirty-nine years. He was for many years a prominent industrial surgeon of northern Wisconsin, doing surgery for several of the lumber companies operating in the vicinity of Wabeno. He was also local surgeon for the Chicago and Northwestern Railway. He operated a private hospital in Wabeno for a number of years and at the time of his death was a member of the medical board and staff of the newly organized Wabeno-Soperton hospital.

He was a member of the Marinette–Florence County Medical Society, the State Medical Society and the American Medical Association. He was also for many years a member of the American Association of Railway Surgeons and of the Surgical Association of the Chicago and Northwestern Railway. He was an active and respected member of the community to which he dedicated his life,—a true prototype of the rapidly disappearing but much loved family doctor.

He is survived by his widow, two sons and one daughter. R. J.

Dr. John Moeller, Milwaukee, died at his home on July second, at the age of 74 years.

Dr. Moeller began his study of medicine at Rush Medical College and finished his medical work in Cincinnati. He had practiced medicine in Milwaukee for forty-three years, retiring from active work in 1930.

He is survived by his widow, two sons, and one daughter.

Dr. J. G. Seidel, Warrens, died on June 19th at St. Mary's hospital, Sparta, following a long illness.

Dr. Seidel was born at Columbus, Ohio, November 15, 1856, and was a graduate of Hahnemann Medical College, Chicago, in 1891. With the exception of five years of practice in Baraboo, he spent all of his time in Warrens.

He is survived by his widow, two sons and one daughter.

SOCIETY RECORDS

NEW MEMBERS

Harry G. Walters, Cor. Main and High Sts., Racine.

Carl E. Bellehumeur, 1626 Wisconsin Ave., Milwaukee.

Lother E. Rauchschwalbe, 213 Metropolitan Blk., Milwaukee.

James M. McCabe, Sun Prairie.

M. E. Ross, Brodhead.

William M. Sproul, Milwaukee Sanitarium, Wauwatosa.

F. G. Drischel, Wisconsin General Hospital, Madison.

Lester W. Paul, Wisconsin General Hospital, Madison.

A. Z. Domine, Black River Falls.

Wm. J. Harrington, 134 E. College Ave., Appleton.

Leland C. Dietsch, Plymouth.

Leo Bleyer, Kenosha.

Richard W. Farnsworth, Janesville.

D. D. Frawley, Appleton.

Donald R. Peterson, Independence.

H. E. Breckenridge, Wisconsin Veterans Home, Racine County.

Charles E. Wall, 910 South 8th St., Manitowoc.

Nathan Schneck, 817 South 8th St., Manitowoc.

C. R. Pearson, Wisconsin General Hospital, Madison.

John F. Wyman, 1545 So. Layton Blvd., Milwaukee.

Max Bornstein, 205 E. Wisconsin Ave., Milwaukee.

Changes in Address

Burton Clark, Jr., Oshkosh to Lakeside Hospital, Cleveland, Ohio.

F. B. Western, Racine to 5777 Kensington Road, Detroit, Mich.

R. C. Lowe, Richland Center to 118 W. Wisconsin Ave., Neenah.

Alfred J. Roach, Jr., Bayfield to 234 Knight Hotel Bldg., Ashland.

A. L. Millard, Marshfield to Insurance Bldg., Appleton.

Geo. N. Pratt, Appleton to 130 W. Wisconsin Ave., Neenah.

F. J. Hodges, Madison to 10 Orchard Hill Road, Ann Arbor, Mich.

H. F. Beglinger, Neenah to F. R. A. Bldg., Oshkosh.

A. R. Bellerue, Waupaca to F. R. A. Bldg., Oshkosh.

Resignations

Emil Gunther, Sheboygan.

Wisconsin births in 1930 reached a total of 56,497 to mark an increase of 904 over those of the preceding year, according to a tentative report of the Bureau of Vital Statistics, State Board of Health. The 1929 births had set the lowest total since 1920, the records of the bureau showed, and if the marked falling off two years ago was due largely to economic depression, the gain in 1930 may be regarded as a harbinger of returning prosperity. Rural births comprised 29,031 of the 1930, the board's survey revealed, as compared with 27,466 urban births.

* * *

More increases in the number of alcoholism cases in Wisconsin in the month of May as compared with a year ago were disclosed in a report on mortality statistics made public by the State Board of Health. While the causes of death from tuberculosis and cancer were declining, a comparative study of deaths from alcoholism showed twenty more deaths from this source in May this year than one year ago. Last year the deaths from alcoholism were five, as compared with twenty-five from May. The State Board of Health was unable to explain the increase in deaths from this source and admitted that even state hospitals' statistics showed that deaths from this source were increasing.

* * *

How the correct cookery of egg white may have a great deal to do with preventing eczema, hives and asthma from which young children often suffer as a result of being fed raw egg white, was recently explained by Miss Helen Parsons of the Home Economics Nutrition Department of the University of Wisconsin.

In her studies of the effect of egg white in the diet of rats, Miss Parsons used egg whites in three different forms—raw, slightly cooked, or boiled for one-half hour. She found that the rats which were fed raw egg white had sore mouths, and severe skin trouble as well as nervous symptoms. Egg white that has only slightly cooked (coddled) making out a soft jelly, did not improve the condition. A cure for these symptoms in rats was found to be effected by feeding egg white which had been cooked in boiling water for a half hour.

* * *

Senator Thomas M. Duncan, Milwaukee socialist, has become executive secretary to Gov. Philip F. La Follette. Senator Duncan is admittedly one of the most able men to ever serve in the legislature and he has been a La Follette aide since the election.

Governor La Follette Vetoes Chiropractic Proposal Permitting Them to Treat Compensation Cases

Wisconsin chiropractors lost their only legislative proposal when Governor La Follette vetoed the Grobschmidt bill at the close of the legislative session. The Governor declared that the bill might mislead employees and that chiropractic treatment could not be said to be satisfactory substitute for the medical and surgical treatment now provided in the act. The veto follows:

State of Wisconsin,
Executive Office.

To the Honorable, the Assembly:

Bill No. 497, A., is herewith returned without my approval.

This Bill proposes to make chiropractic treatment an optional substitute for medical treatment under the provisions of the Workmen's Compensation Act.

This Bill does not involve the right of an individual to select such treatment as he may believe curative. Within a very wide range, every individual is allowed a wide latitude in selecting and providing for the care of his bodily ills, as he may determine. This Bill involves the question as to whether or not the State is to approve this particular form of treatment under the terms of the Workmen's Compensation Act and to place it upon a footing of equality with that of general medical services.

In recommending that the Bill be vetoed, the Industrial Commission advises as follows:

"If this Bill were enacted, there is a possibility that employes might be misled and prejudice their rights under the Workmen's Compensation Act, since section 102.09 subsection (1) paragraph (c) provides that 'no compensation shall be payable for the death or disability of an employe, if his death be caused by or insofar as his disability may be aggravated, caused or continued by an unreasonable refusal or neglect to submit to or follow any competent and reasonable surgical treatment.' In any case where the Commission found that the chiropractic treatment was not a satisfactory substitute for competent and reasonable surgical treatment, an injured employe would have sacrificed his right to compensation for any added disability due to the fact that he had selected chiropractic treatment instead of such surgical treatment."

For the reasons stated, I return this Bill without my approval.

Respectfully submitted,

PHILIP F. LA FOLLETTE,
Governor.

June 22, 1931,
Madison, Wisconsin.

DECISION TO BE APPEALED

Circuit Judge A. G. Zimmermann in the case of *Henry Karsten v. Industrial Commission and City of Green Bay,* decided on May 28, that the city would be required to pay for chiropractic treatment under the Workmen's Compensation Act, to an injured city fireman, after his discharge by regular physicians, and he went to the chiropractor at the suggestion of the fire chief, with a promise that the city would pay the bill.

Judge Zimmermann's opinion, however, directly holds that chiropractic treatments are within the term "medical treatment" as used in the Workmen's Compensation Act, and the Judge bases his decision upon the decision of the Wisconsin Supreme Court, (Kuechler v. Volgmann, 180 Wis. 238) holding that the practice of chiropractic is the practice of medicine, and without discussion of the specific treatment of Christian Science, which the supreme court also has held is the practice of medicine, and which special treatment would, therefore indicate that chiropractors would be required also to be specially mentioned.

The Judge also omitted any discussion in his opinion of the definition of the statute that a physician is one who has been licensed by the State Board of Medical Examiners, and the requirement of the Workmen's Compensation law that only physicians may be placed upon the panel. The Industrial Commission and the city of Green Bay will appeal the case to the Supreme Court.

The result of the decision, if it is affirmed by the Supreme Court, will be that only if the employer has not maintained the statutory panel of physicians, may the injured employe go to a chiropractor, unless the interpretation be extended to include chiropractors also as physicians under the terms of the compensation law. This would seem a not unlikely result of holding them to be included within "medical treatment" as used in the act, and the inconsistency of this with the specific statutory definition of physician will be one of the principal arguments of the commission to the Supreme Court.

One Hundred Twenty-Five Contribute to Beaumont Memorial: Total Within Two Hundred Dollars of Amount Needed

With contributions from upwards of 125 Wisconsin physicians, but $200 is now lacking of the amount needed for the Beaumont Memorial to be erected at Prairie du Chien early this fall. The Memorial will be a bronze plaque upon a large granite boulder and will be placed on the main trunk highway entering the city as result of the voluntary contributions of Wisconsin physicians.

"The Committee appointed by your Society wishes to express its appreciation to those who have contributed and to express the hope that additional members may find it possible to forward contributions at this time", declared Chairman Curtis A. Evans, Milwaukee, late in July.

"Some have felt that they must send in $10 or nothing. This is an error for we will accept any amount but it must not exceed $10. This limitation was placed that the Memorial might be erected by our membership as a whole and not merely representative of some few.

"A complete list of contributors will be published in the next issue of the Journal at which time contributions will be closed. As Chairman of the Committee, every member of which has given so generously of his time, I express the hope that additional receipts within the next month will supply the rest of the funds essential to the erection of this simple but impressive marker to the memory of one whose great work was accomplished in our own state."

Contributions to July 27th have been received from the following:

Algoma:
Foshion, H. V.

Antigo:
Wright, J. C.

Ashland:
Prentice, J. W.

Bloomington:
Baldwin, F. H.

Columbus:
Schmeling, A. F.

Cross Plains:
Froggatt, W. E. L.

Dorchester:
Foley, F. P.

Durand:
Schulberg, P. A.

Elkhorn:
Herzog, J. V.

Green Bay:
Kelly, Webber

Kewaunee:
Wochos, W. M.

La Crosse:
Bannen, W. E.
Evans, Edward
Evans, James A.
Gundersen, Gunnar
Henke, W. A.
McGarty, M. A.

Madison:
Bardeen, C. R.
Bunting, C. H.
Crownhart, J. G.
Davis, F. A.
Ewell, G. H.
Fox, Philip R.
Ganser, Wm. J.
Harper, C. A.
Head, Louis R.
Jackson, Reginald H.
Middleton, Wm. S.
Miller, Wm. Snow
Schmidt, Erwin R.
Waters, R. M.

Maiden Rock:
Hogan, John

Manitowoc:
Gleason, C. M.
Steckbauer, J. W.
Turgasen, F. E.

Marinette:
Axtell, Luella E.
Redelings, T. J.

Menasha:
Forkin, G. E.

Menomonie:
Butler, F. E.
Heising, A. F.

Milwaukee:
Baum, E. L.
Beckman, Harry
Blumenthal, R. W.
Brown, G. V. I.
Carson, W. J.
Cron, R. S.
Davis, Carl Henry
Dearholt, H. E.
Dieterle, J. O.
Eberbach, Carl W.
Egan, W. J.
Eisenberg, J. J.
Evans, C. A.
Everts, Edwin L.
Federspiel, M. N.
Fellman, G. H.
Fletcher, E. A.
Foerster, O. H.
Gaenslen, F. J.
Gordon, John S.
Gramling, Henry
Gramling, J. J.
Hipke, G. A.
Hitz, H. B.
Holbrook, A. T.
Koch, M. J.
Kristjanson, H. T.
Krzysko, Stanley
Ladewig, A. W.
LeCron, W. L.
Leitch, G. W.
Lotz, Oscar
Lynch, D. W.
McGrath, B. F.
Montgomery, Alex
Murphy, F. D.
Olsen, Henry
Raine, Forrester
Rasmussen, H.
Salinko, S.
Sayle, R. G.
Schlomovitz, B. H.
Schlueter, U. A.
Schmitt, Gustav
Schmitt, Philip
Sifton, H. A.
Sproule, Ralph
Tharinger, E. L.
Tolan, T. L.
Yates, J. L.

Mineral Point:
Ludden, H. D.

Oconomowoc:
Mundt, R. C.
Rogers, A. W.
Wilkinson, J. F.

Omro:
Fleury, F. D.

Oshkosh:
Connell, F. Gregory
Steele, G. M.

Plymouth:
Radloff, A. C.

Prescott:
Dill, G. M.

Racine:
Brehm, T. G.
Christensen, F. C.
DeWitt, Chester
Fazen, L. E.
Miller, Hubert C.

Random Lake:
Bemis, Ira M.

Ripon:
Senn, C. U.

Sheboygan:
Sheboygan Clinic
Juckem, G. J.

Stevens Point:
Coon, H. M.
Viroqua:
Ludden, R. H.
Watertown:
Abelman, T. C. H.

Wausau:
Boslough, A. W.
Smith, Joseph F.
Wautoma:
Karnopp, G. L.

Wauwatosa:
Sleyster, Rock

Woodville:
Blom, Julius

New Haven, Conn.:
Fulton, J. F.
Tallahassee, Fla.:
Stratman-Thomas, W. K.

Delegates and Alternates Who Will Comprise 1931 House of Delegates

Society	*Delegate*	*Alternate*
Ashland-B-I	M. S. Hosmer, Ashland	J. M. Dodd, Ashland
Barron-W-S-B	D. L. Dawson, Rice Lake	
Brown-Kewaunee	R. M. Carter, Green Bay	A. O. Olmsted, Green Bay
Calumet	J. W. Goggins, Chilton	F. P. Knauf, Kiel
Chippewa	A. A. Somers, Chippewa Falls	C. B. Hatleberg, Chippewa Falls
Clark	H. H. Christofferson, Colby	R. H. Wink, Granton
Columbia	C. W. Henney, Portage	H. E. Gillette, Pardeeville
Crawford	F. J. Antoine, Prairie du Chien	
Dane	W. F. Lorenz, Madison	L. W. Peterson, Sun Prairie
	A. S. Thompson, Mt. Horeb	G. E. Bilstad, Cambridge
Dodge	E. P. Webb, Beaver Dam	A. W. Hammond, Beaver Dam
Door		
Douglas	T. J. O'Leary, Superior	C. W. Giesen, Superior
Eau Claire & Associated	F. C. Kinsman, Eau Claire	R. E. Mitchell, Eau Claire
	F. E. Butler, Menomonie	O. J. Blosmo, Menomonie
Fond du Lac	S. E. Gavin, Fond du Lac	H. R. Sharpe, Fond du Lac
Grant	E. H. Spiegelberg, Boscobel	M. A. Bailey, Fennimore
Green	J. F. Mauermann, Monroe	W. G. Bear, Monroe
Green Lake-W-A	A. J. Wiesender, Berlin	
Iowa	H. M. Walker, Dodgeville	T. A. Hagerup, Dodgeville
Jefferson	H. P. Bowen, Watertown	W. S. Waite, Watertown
Juneau	C. C. Vogel, Elroy	
Kenosha	J. H. Cleary, Kenosha	
La Crosse	Gunnar Gundersen, La Crosse	R. E. Flynn, La Crosse
Lafayette		
Langlade	J. C. Wright, Antigo	J. W. Lambert, Antigo
Lincoln	E. O. Ravn, Merrill	K. A. Morris, Merrill
Manitowoc	C. M. Gleason, Manitowoc	A. J. Shimek, Manitowoc
Marathon	S. M. B. Smith, Wausau	L. M. Pearson, Wausau
Marinette-Florence	G. R. Duer, Marinette	J. V. May, Marinette
Milwaukee	W. M. Kearns, Straus Bldg.	C. W. Morter, 230 Wis. Ave.
	M. G. Peterman, 167 17th St.	A. B. Schwartz, 418 E. North Ave.
	Bernard Krueger, Cudahy	S. G. Higgins, Wells Bldg.
	F. A. Thompson, 1st Nat. Bank	A. A. Pleyte, 1018 N. Jefferson St.
	E. F. Peterson, Wauwatosa	R. J. Dalton, Wells Bldg.
	D. E. W. Wenstrand, 210 E. Wis. Ave.	T. S. O'Malley, Straus Bldg.
	Edith McCann, 425 E. Wis. Ave.	J. J. Pink, Wells Bldg.
	J. O. Dieterle, 425 E. Wis. Ave.	Oscar Lotz, Wells Bldg.
	E. W. Miller, Pub. Serv. Bldg.	F. D. Murphy, Wis. Theatre Bldg.
	S. J. Seeger, Wells Bldg	H. G. Schumm, 425 E. Wis. Ave.
	H. J. Gramling, 2203 S. Layton Blvd.	G. W. Neilson, 776 3rd St.
	H. W. Powers, 123 Wis. Ave.	R. E. Fitzgerald, 1002 Teutonia
	C. J. Coffey, Majestic Bldg.	F. J. Gaenslen, 425 E. Wis. Ave.
Monroe	A. E. Winter, Tomah	Victor Cremer, Tomah
Oconto	J. S. Dougherty, Suring	W. R. Berg, Gillett
Oneida-F-V	I. E. Schiek, Rhinelander	
Outagamie	C. D. Boyd, Kaukauna	C. D. Neidhold, Appleton
Pierce-St. Croix	A. E. McMahon, Glenwood City	H. P. Conway, Spring Valley
Polk	R. G. Arveson, Frederic	J. D. Nicholson, Milltown
Portage	E. P. Crosby, Stevens Point	E. E. Kidder, Stevens Point
Price-Taylor	F. W. Mitchell, Medford	G. E. MacKinnon, Prentice
Racine	H. B. Keland, Racine	L. E. Fazen, Racine
Richland	G. H. Benson, Richland Center	C. F. Dull, Richland Center
Rock	Wm. J. Allen, Beloit	H. O. Delaney, Beloit
Sauk	H. J. Irwin, Baraboo	Edw. McGrath, Baraboo
Shawano	A. J. Gates, Tigerton	E. E. Evenson, Wittenberg
Sheboygan	R. C. Meyer, Plymouth	C. J. Weber, Sheboygan
Trempealeau-J-B	C. F. Peterson, Independence	H. A. Jegi, Galesville
Vernon	W. H. Remer, Chaseburg	P. H. Hansberry, Hillsboro
Walworth	R. L. Jacobson, Delavan	
Washington-Ozaukee	H. M. Lynch, Allenton	C. Balkwill, Grafton
Waukesha	H. T. Barnes, Delafield	H. A. Peters, Oconomowoc
Waupaca	F. E. Chandler, Waupaca	R. K. Irvine, Manawa
Winnebago	J. W. Lockhart, Oshkosh	R. B. Rogers, Oshkosh
Wood	F. X. Pemainville, Wis. Rapids	K. H. Doege, Marshfield

One Hundred and Six on Scientific Program for 90th Anniversary Meeting at Madison, September 9th, 10th, 11th

A scientific program that will embrace presentations by one hundred and six members and guests is the announcement of Dr. Arthur Sullivan, Chairman of the Committee on Scientific Work for the September annual meeting. With the release of the final program by days and hours, final arrangements for the meeting that will bring upwards of 1,000 Wisconsin physicians to the Memorial Union Building at Madison next month are now rapidly nearing completion.

While the scientific sessions open early Wednesday morning, September 9th, they will be preceded on Tuesday by the Annual Golf Tournament during the morning and afternoon, a meeting of the Council at noon, and the opening meeting of the House of Delegates at the Memorial Union Building Tuesday evening. The Delegates will meet for subsequent sessions on both Wednesday and Thursday.

Alumni luncheons will be held on Wednesday noon with a buffet supper for the members on Wednesday evening to be followed by an evening scientific program. Thursday noon will again be devoted to the Round Table luncheons with a limit of twenty for attendance at each and additional time has been allotted that the discussion feature of these group meetings may be very complete.

The ladies will be entertained by the Auxiliary on Thursday noon at a luncheon meeting. Following a brief business meeting and a short program, an informal reception will be held after which the members and their families will be served at a buffet supper in the Union Building. All will attend the opening of the Thursday evening session which will be introduced with presentation of the Council awards. During the remainder of the evening the ladies will be entertained at bridge while members conclude the scientific program.

The Friday program will conclude the three-day session. Sectional meetings will be held each afternoon from 1:45 to 3:40 to permit of a wide variety of subject matter and a general session for an hour will conclude each afternoon program.

The detailed scientific program follows:

TUESDAY, SEPTEMBER 8

9:00 A. M. Maple Bluff Golf Course open for Practice Play. Golf Chairman Dr. Albert R. Tormey, Madison, Wisconsin.

10:00 A. M. Golf Tournament — Maple Bluff Golf Club.

Noon Council Meeting.

7:00 P. M. House of Delegates, First Session.

WEDNESDAY, SEPTEMBER 9

7:30 A. M. Registration—Memorial Union Building. Exhibits open.

8:00 A. M. Scientific Medical Motion Pictures With Sound, furnished by the Petrolagar Laboratories.

a) "Anatomy of The Female Pelvis and Perineum" by Doctors H. B. Kellogg and W. F. Windle of the Department of Anatomy, Northwestern University, Chicago—two reels—thirty-five minutes.

b) "Suspension Of The Uterus For Retro-Displacement" by Dr. H. O. Jones, associate professor of Gynecology, Northwestern University, Chicago—one reel—fifteen minutes.

c) "Sub-Total Abdominal Hysterectomy For Uterine Fibroids" by Dr. H. O. Jones, Northwestern University, Chicago—two reels—thirty-five minutes.

9:25 A. M. Dr. Volney B. Hyslop, Madison, "Principles To Be Observed In The Treatment Of Congenital Harelip And Cleft Palate."

9:50 A. M. Dr. Robert Burns, Madison, "Osteomyelitis."

10:15 A. M. Intermission (See The Exhibits).

10:30 A. M. Dr. Hartwig M. Stang, Eau Claire, "Intravenous Urography; Its Place In Urology And General Practice."

10:55 A. M. Dr. Harry B. Culver, Chicago, Illinois, "Significance Of Renal Pain." *(Guest)*

11:20 A. M. Dr. Hermon C. Bumpus, Rochester, Minnesota, "Punch Prostatectomy." *(Guest)*

11:45 A. M. Dr. Joseph F. Smith, Wausau, "Report Of The A. M. A. House Of Delegates."

12:00 Noon Alumni Luncheon Meetings.

1:45 P. M. **ROOM A Dr. John P. Harkins, Madison, presiding.**

Dr. James K. Trumbo, Wausau, "Ocular Manifestations Of Focal Infections."

2:10 P. M. Dr. Edward S. Ryan, Sheboygan, "Conservative Treatment Of Nasal Infections."

Memorial hall in the Union building.

2:35 P. M. Dr. Mark Nesbit, Madison, "The Eye And General Medicine."

3:00 P. M. Dr. Frederick A. Davis, Madison, "Experience With Avertin In Eye Cases."

3:25 P. M. Dr. Henry B. Hitz, Milwaukee, "Acute Mastoiditis."

1:45 P. M. **ROOM B Dr. William S. Middleton, Madison, presiding.**

Dr. John H. Karsten, Horicon, "The Small Town Physician In General Practice And His Relationship To The Medical Profession."

2:10 P. M. Dr. Robert C. Thackeray, Racine, "Determination Of Circulatory Fitness With A Flarimeter."

2:35 P. M. Dr. Charles M. Gleason, Manitowoc, "Relation Of The Life Insurance Examiner, To The Agent, The Company, And The Applicant."

3:00 P. M. Dr. Herman T. Schlegel, Wausau, "Treatment Of Asthma."

3:25 P. M. Dr. Hugh P. Greeley, Madison, "Multiple Sensitiveness In Hay Fever And Asthma."

1:45 P. M. **ROOM C Dr. Walter G. Sexton, Marshfield, presiding.**

Dr. Otto V. Pawlisch, Reedsburg, "Problems Of Arteriosclerosis In General Practice."

2:10 P. M. Dr. Roger C. Cantwell, Shawano, "Substernal Pain."

2:35 P. M. Dr. George V. Lynch, Oshkosh, "Pathological Conditions Of The Genito-urinary Tract That Require Transplanting The Ureters Into The Sigmoid."

3:00 P. M. Dr. Francis B. McMahon, Milwaukee, "Treatment Of Cancer Of The Mouth." (Slides)

3:25 P. M. Dr. Arthur V. DeNeveu, Milwaukee, "Skull Fractures And Treatment; A Review Of 600 Cases."

3:50 P. M. Intermission (See The Exhibits).

4:00 P. M. **General Session.**

President's Address—Dr. C. A. Harper, Madison.

4:25 P. M. Dr. W. L. Benedict, Rochester, Minnesota, "Infection Of The Pelvic Organs Of The Female In Relationship To Diseases Of The Eye." *(Guest)*

4:50 P. M. Dr. Melvin S. Henderson, Rochester, Minnesota, "Fractures Of The Ankle Joint, (Pott's)." *(Guest)*

5:45 P. M. **Members' Buffet Supper.**

7:30 P. M. **Evening Session.**

Dr. John W. Powers, Milwaukee, "Evaluation Of The Various Treatments For Ununited Fractures Of The Hip."

7:55 P. M. Dr. William F. Braasch, Rochester, Minnesota, "Urology And The General Practitioner." *(Guest)*

8:20 P. M. Dr. Gordon B. New, Rochester, Minnesota, "The Developments In The Treatment Of Deformities Of The Face And Neck." (Slides) *(Guest)*

8:45 P. M. Dr. John O. Dieterle, Milwaukee, "Some Observations In The Diagnosis And Treatment Of Gas Gangrene Complicating Compound Fractures."

THURSDAY, SEPTEMBER 10

8:00 A. M. Dr. Joseph C. Bloodgood, Baltimore, Maryland, "What Every Doctor Should Know About Pathology." *(Guest)*

9:00 A. M. Dr. James B. Vedder, Marshfield, "External Cephalic Version." (Motion Picture)

9:25 A. M. Dr. Andrew J. Weber, Milwaukee, "Arthritis Of The Spine With Reference To Industrial Accidents."

9:50 A. M. Dr. Reginald H. Jackson, Madison, "Spinal Anesthesia—Resume Of Observations Based On 3,000 Inductions. Cinematography Film To Demonstrate Technique And Advantages Conferred On The Patient And Surgeon, By This Method."

10:15 A. M. Intermission (See The Exhibits).

10:30 A. M. Dr. Mynie G. Peterman, Milwaukee, "The Treatment Of Epilepsy In Children."

A portion of the main meeting room.

10:55 A. M. Dr. Roy D. McClure, Detroit, Michigan, "The Results Of The Use Of Iodine Salt In Detroit As Noted In The Effect Upon The Demand For Surgery." *(Guest)*

11:20 A. M. Dr. Eugene S. Sullivan, Madison, "The Surgical Problem Of Pelvic Endometriosis."

11:45 A. M. Dr. W. E. Bannen, LaCrosse, "Report On Sections And Section Work Of The A. M. A. Meeting."

12:00 NOON–2:15 P. M. ROUND TABLE LUNCHEONS.

1 TEA ROOM **Dr. Louis R. Head, Madison, presiding.**

Dr. John W. Harris, Madison, "Problems In Obstetrics a) Induction Of Labor, b) Occiput Posterior, c) Breech."

General Discussion.

2 BEEF EATER'S ROOM **Dr. Hans H. Reese, Madison, presiding.**

Dr. Erwin R. Schmidt, Madison, "Problems In Surgery a) Cancer Of Breast, b) Cancer Of Uterus."

General Discussion.

3 LAW BOOK ROOM **Dr. Elmer L. Sevringhaus, Madison, presiding.**

Dr. Robert VanValzah, Madison, "Problems In Medicine a) Cardiac Decompensation, b) Bronchopneumonia."

General Discussion.

4 ROUND TABLE ROOM **Dr. Walter H. Sheldon, Madison, presiding.**

Dr. Robert Burns, Madison, "Problems In Fractures a) Pott's Fracture, b) Fracture Of The Os Calcis."

General Discussion.

5 MAIN DINING ROOM **Dr. Horace K. Tenney, Madison, presiding.**

Dr. Henry C. Johnson, Madison, "Problems In Pediatrics a) Nephritis, b) Rickets."

General Discussion.

6 POP OVER ROOM **Dr. John P. Harkins, Madison, presiding.**

Dr. E. E. Neff, Madison, "Problems In Nose, Throat And Ear Surgery."

General Discussion.

The bar in the Rathskellar.

7 OLD MADISON ROOM Dr. W. D. Stovall, Madison, presiding.
Dr. Bowman C. Crowell, Chicago, Registrar Committee on Bone Sarcoma, A. C. of S., "Organization Of Cancer Clinics in General Hospitals."

2:15 P. M. ROOM A Dr. William S. Middleton, Madison, presiding.
Dr. John C. Doolittle, Lancaster, "Some Lessons Learned From Our Mistakes."

2:40 P. M. Dr. Arthur E. McMahon, Glenwood City, "Obstetrical Anesthesia And Analgesia In General Practice."

3:05 P. M. Dr. Francis E. Butler, Menomonie, "Two Years' Experience With Spinal Anesthesia."

3:30 P. M. Dr. Ralph M. Waters, Madison, "Clinical Aspects Of Anoxemia."

2:15 P. M. ROOM B Dr. Walter G. Sexton, Marshfield, presiding.
Dr. W. G. Riopelle, Beaver Dam, "Medical Economics."

2:40 P. M. Dr. Albert A. Axley, Washburn, "The Small Community Hospital."

3:05 P. M. Dr. Harold M. Coon, Stevens Point, "Positive Factors In The Diagnosis Of Pulmonary Tuberculosis."

3:30 P. M. Dr. John L. Garvey, Milwaukee, "Spontaneous Subarachnoid Hemorrhage And The Clinical Significance Of Blood In The Spinal Fluid."

2:15 P. M. ROOM C Dr. Eugene S. Sullivan, Madison, presiding.
Dr. Leslie W. Tasche, Sheboygan, "Carcinoma Of The Oesophagus."

2:40 P. M. Dr. Clarence E. Hatleberg, Chippewa Falls, "Diagnosis And Treatment Of Ectopic Pregnancy."

3:05 P. M. Dr. Robert L. MacCornack, Whitehall, "Embolism And Thrombosis Of The Mesenteric Vessels."

3:30 P. M. Dr. Guy R. Duer, Marinette, "Practical Problems In The Practice Of Medicine."

3:55 P. M. Intermission (See The Exhibits).

4:05 P. M. General Session.
Dr. Arthur H. Curtis, Chicago, Illinois, "Stricture Of The Uterine Cervix, Its Etiology, Clinical Characteristics, And Complications; — Treatment." *(Guest)*

4:30 P. M. Dr. Archie A. Skemp, LaCrosse, "The General Practitioner's Response To The Challenge Of Obstetrics."

4:55 P. M. President-Elect's Address — Dr. Otho Fiedler, Sheboygan.

5:30 P. M. Buffet Supper for members and families.

7:30 P. M. Evening Session.
Honorary Awards By The Council.

7:45 P. M. Dr. Justin D. Leahy, Park Falls, "Injuries Of The Back."

8:10 P. M. Dr. H. Earl Conwell, Birmingham, Alabama, "Fractures Of The Spinal Vertebrae Without Cord Injury." (Lantern Slides, A Report Of 100 Cases." *(Guest)*

8:35 P. M. Dr. Ernest W. Miller, Milwaukee, "Electric Burns."

9:00 P. M. Dr. John M. Dodd, Ashland, "Idealism In The Practice Of Medicine."

FRIDAY, SEPTEMBER 11

8:00 A. M. Dr. Dean Lewis, Baltimore, Maryland, "Aneurysms, Congenital And Traumatic." *(Guest)*

9:00 A. M. Dr. Ralph M. Carter, Green Bay, "Skeletal Traction In Fractures Of The Lower Extremities." (Slides)

9:25 A. M. Dr. Roy P. Potter, Marshfield, "Roentgenological Findings In Non-Tuberculous Lesions Of The Hip." (Lantern Slides)

9:50 A. M. Dr. Joseph Dean, Madison, "Appendicitis."

10:15 A. M. Intermission (See The Exhibits).

10:30 A. M. Dr. Herman O. McPheeters, Minneapolis, Minnesota, "The Mechanics Of The Reverse Flow Of Blood In Varicose Veins And Its Clinical Application To The Injection Treatment." (Slides) *(Guest)*

10:55 A. M. Dr. Samuel J. Fogelson, Chicago, Illinois, "The Present Status Of The Mucin Treatment In Peptic Ulcer." *(Guest)*

11:20 A. M. Dr. Karl W. Doege, Marshfield, "What I Think About Cancer."

11:45 A. M. Dr. J. Gurney Taylor, Milwaukee, "Report On The Scientific Exhibits At The A. M. A. Meeting."

The Rathskellar where the buffet supper-smoker will be held.

1:30 P. M. **ROOM A Dr. Walter G. Sexton, Marshfield, presiding.**

Dr. Julius F. Mauermann, Monroe, "Catarrhal Enteritis Simulating Pelvic Disease In Women."

1:55 P. M. Dr. Edwin F. Schneiders, Madison, "The Early Recognition, And Adequate Treatment Of Pre-Cancerous Lesions Of The Cervix." (Slides)

2:20 P. M. Dr. Gunnar Gundersen, LaCrosse, (and Dr. R. B. Johnson) "Observations Of Duodenal Obstruction."

2:45 P. M. Dr. Carl S. Williamson, Green Bay, "Surgical Indications In Peptic Ulcers."

1:30 P. M. **ROOM B Dr. Ray C. Blankinship, Madison, presiding.**

1:55 P. M. Dr. Joe N. Sisk, Madison, "Cholecystography."

Dr. Lawrence V. Littig, Madison, "Cholecystography." (Joint Paper With Movie)

2:20 P. M. Dr. Nels Werner and Dr. Garner T. Scullard, Eau Claire, "Evaluation Of The Schilling Blood Count In Diagnosis."

2:45 P. M. Dr. Karl H. Doege, Marshfield, "Cardiac Irregularities."

1:30 P. M. **ROOM C Dr. William S. Middleton, Madison, presiding.**

Dr. Harold R. Fehland, Wausau, "The Anemias Of Adolescence." (Slides)

1:55 P. M. Dr. Edward H. Spiegelberg, Boscobel, "Congenital Pyloric Stenosis."

2:20 P. M. Dr. Everett L. Mason, Eau Claire, "Purpura Hemorrhagica."

2:45 P. M. Dr. Henry A. Sincock, Superior, "The Clinical Signs, Symptoms And Treatment Of Calcium Deficiency In Pregnancy, And Its Influence Upon The Child."

3:10 P. M. Intermission (See The Exhibits).

3:20 P. M. **General Session.**

Dr. Jennings C. Litzenberg, Minneapolis, Minnesota, "The Delivery Of Occiput Posterior." *(Guest)*

3:45 P. M. Dr. Howard L. Beye, Iowa City, Iowa, "Transphrenic Infection." *(Guest)*

4:10 P. M. Dr. Fred W. Rankin, Rochester, Minnesota, "Encouragements In The Surgical Treatment of Cancer Of The Colon And Rectum." *(Guest)*

4:35 P. M. Dr. George B. Eusterman, Rochester, Minnesota, "Observations On Carcinomatous Gastric Lesions Masquerading As Benign Ulcer." *(Guest)*

5:00 P. M. Dr. Charles W. Mayo, Rochester, Minnesota, "Pharyngo-Esophageal Diverticulum." *(Guest)*

SPECIAL CANCER PROGRAM

Through the efforts of the Committee on Cancer, a special program has been arranged for physicians and allied groups during the three days of the meeting. On Wednesday noon, September 9th, Dr. Bloodgood will speak before the Federated Women's Club Luncheon at the Women's Building on "What Every Woman Should Know About Cancer". This address will be open to wives of the members, but request for reservation must be sent to Mr. Crownhart, Secretary of the Society.

Wednesday evening Dr. Bloodgood will address a large dental meeting on "Tumors of the Jaw." As announced in the program, Dr. Bloodgood's address for the profession will be on Thursday morning and a round table luncheon is devoted to the subject of organizing cancer clinics in general hospitals, on Thursday noon. From 9 to 11 Friday morning, Dr. Bloodgood will conduct a clinical pathological conference for pathologists and radiologists only, which will be devoted to a microscopic examination of tumors, discussion of clinical cases and final diagnosis. Tissue, difficult of diagnosis, may be submitted for this conference by forwarding tissue and clinical synopsis to Dr. W. D. Stovall, Madison, by September first. Sections will then be prepared and the case will be discussed.

Reports of Officers and Committees to House of Delegates

CHAIRMAN OF THE COUNCIL

To the 1931 House of Delegates:

This present period of financial pressure calls for an auditing of values on the part of all. While such a survey was made concurrent with the increase in dues, the subject has been constantly on the mind of your Chairman that the expenditures of the Society might bring to the members accomplishments of the greatest possible value.

The budget of a hospital is largely for the purchase of commodities. The budget of your Society, however, is principally concerned with the purchase of services. If this expense be viewed as "overhead" of running the Society, it is far too large. As purchase of services, one appreciates that it is necessary and essential. Measurement of the value must be concerned with a Secretary and his assistants not as running the routine matters of an organization, but from the point of their productive services that may be said to benefit the members.

The first six months of the current year has given to us a demonstration of the truth of this statement. It may be said to be the personal services of the staff that secured the funds essential to a continuation of the Medical Library Service; the veto of the proposal that would have cost physicians of the state some $60,000 a year, and secured the funds essential to continue the very excellent public service of the investigator in the field of law enforcement.

In accordance with your vote of approval, the Council has authorized, and the Society has now secured, the services of Miss Ruth Buellesbach, R. N., as an assistant to the Secretary. Miss Buellesbach, a graduate of the University of Wisconsin, joined the Society the first day of May. The steady growth in correspondence and the detailed work necessary to the success of newer projects has made the services of an assistant essential.

THE BUDGET

Your Society will prosper only as it is representative of the wishes of the great group of its members. While the Council is charged with the duty of preparing the annual budget and has a special committee to consider it in utmost detail before it is even submitted to the Council, we recognize that the budget as well as policies of the Society should represent the group opinion. The Secretary, as the executive officer of the Society, has expressed his desire that a compilation be published here for the information of every member and if any delegate has any suggestions, criticisms or desires a detailed information that cannot well be included in this report, he has but to rise when this report is formally presented to the House. Every question will be answered promptly in as much detail as may be desired.

	Total Budget	Per Member
Salaries—J. G. Crownhart, Secretary*, $566.66; Ruth Buellesbach, Assistant, $175.00; Florence Ripley, Records, $140.00; Ellinore Beck, Stenographer-Files, $140.00	$12,250.00	$6.12½
Rent at $80 a month	960.00	.48
Supplies—This item includes postage, telephone, telegraph,		

* The Wisconsin Medical Journal, self-supporting, pays the Secretary $1,200 a year so that his total salary is $8,000 a year, dating from January, 1930.

	Total Budget	Per Member
office supplies, stationery, and other miscellaneous items of office overhead	2,200.00	1.10
Press Service—Furnishing 400 daily and weekly papers an article a week on the advances of medicine and its facilities	2,750.00	1.37½
Travel—Travel expenses of the Secretary	450.00	.22½
Cancer—Special appropriation for 1931	500.00	.25
Editorial Board — Special appropriation for 1931	2,500.00	1.25
Annual Meeting — Appropriation in excess of exhibit revenue	1,800.00	.90
Foundation Fund—Special appropriation to complete legal establishment of fund and publish terms	600.00	.30
Public Policy—For work of this Committee during the legislative year, bulletins to members, legal expense in analyzing bills, etc.	2,000.00	1.00
Hygeia — Presenting subscriptions to state officers, legislators, teachers colleges, etc.	450.00	.22½
A. M. A. Delegates—Rail and Pullman expense only. Three delegates to Philadelphia	300.00	.15
Secretaries' Conference — Expenses of speakers and secretaries of component county societies to annual conference, and stenotype report	800.00	.40
Legal—Expense in obtaining answers to legal questions affecting the general membership in the practice of medicine	600.00	.30
Council and Committees—Expense of holding meetings throughout the year	400.00	.20
Treasurer—Honorarium to accountant employed by Treasurer	300.00	.15
Unassigned — Held for appropriation to care for projects arising during the year	1,140.00	.57½
Receipts from 2,000 members, $30,000	$30,000.00	$15.00 Dues

SUMMARY

While your Council held its meeting in January to outline plans for the year, in a larger sense it is in continuous session. Not a month goes by but what it receives at least one detailed letter from the Secretary presenting a new problem necessitating Council opinion or action.

The Council is in fact a Board of Directors for an organization that is charged with protecting and promoting the just interests of a membership that has an investment in education and equipment of over $30,000,000. It does not believe that a thousandth part of this investment is large for an annual budget to accomplish the work assigned. As chairman, I would stress the importance of electing to the Council those fitted by experience, and by interest willing to devote the time necessary, to do a real service for the medical profession of this state, and thereby to the public at large.

Respectfully submitted,

ARTHUR W. ROGERS,
Chairman of the Council.

REPORT OF THE SECRETARY

To the 1931 House of Delegates:

During the calendar year 1930, your Society received dues from 2200 members of which number 2050 had paid by July first. In the first seven months of the current year 2010 members have paid dues. It is evident that members generally appreciate that their Society is endeavoring to return dividends to them that will far offset their dues, and this membership record, in times of economic pressure, is considered excellent.

THE JOURNAL

Despite a reduced advertising income that has been experienced by all Journals, your Wisconsin Medical Journal has not attempted to reduce its content and has made every effort to present not only a well-edited scientific journal, but one that includes material of distinct value to the readers in fields allied to the practice of medicine. In this connection we have again published a summary of income tax reductions that refer only to physicians, articles relating to the trends in medical service and several legislative hearings in full. While the Journal sustained a small loss in 1930 and will again have a loss in 1931, the working capital accumulated by previous profitable years will enable the Journal as such, to continue for its seventh year without financial aid from the society. The 1930 Auditor's report is printed herewith.

LEGISLATURE

Since this House met a year ago, nine of the twelve months have necessarily demanded that the executive officer devote his time to legislative proposals that affect the public health. The report of some of the work accomplished will be found detailed in the report of the Committee on Public Policy.

OTHER ACTIVITIES

In addition, the Society has made distinct progress along other lines, only those of major importance being listed here:

1. Culminating three years of tentative proposals, your Secretary is now serving as Secretary-Treasurer of the Wisconsin Hospital Association. The compensation of $150 a year is made to the State Medical Society and not to the Secretary. While we have but entered upon this project, late legislative activity has demonstrated that the problems of the hospital and physician are in the main of an identical nature. By the close cooperation that will maintain under the present arrangement, it is believed that the future may show that medical lead-

ership has been of distinct value to the hospitals of the state, and that the more active support of the hospitals has been of value in accomplishing the results both Societies desire.

2. Despite a state budget that cut off medical extension effort, arrangements since have been perfected that insure continuance of the medical library service and continuance in considerable part of the free lecture service that has met with such favorable response from the outlying county medical societies. The postgraduate courses on (1) insulin and (2) nose and throat have been conducted successfully in addition to the planned program for the year.

3. Through the joint efforts of the Medical Society of Milwaukee County and the State Society, radio talks have been reinstated over WTMJ, and the State Society is now conducting a series over a hookup of WHA and WIBA. Further extension of the radio health talks is in process.

4. Following the introduction of a bill that in effect would have licensed nurses in industrial plants to practice medicine so far as employees and their families were concerned (subsequently killed), several conferences were held on this subject with the proponents. As a result a special committee of the Society was appointed to draft a set of proposed standing orders for nurses in industrial plants, to be signed by the physician on the panel of the plant. This committee has been working actively and the orders will be ready shortly. It is anticipated that this will materially reduce the complaints that have previously arisen because of such nurses exceeding their authority.

5. With the employment of a full time Secretary for the Wisconsin State Dental Society, a cordial and active relationship has existed that has reflected material benefits to both societies.

6. Arrangements have been made by the Dean of the Marquette University School of Medicine so that a fund will be available to pay the travel expense of members of their faculty invited to address county and district societies in the state. It is anticipated that a list of speakers and subjects will be submitted shortly to the officers of the component societies through the offices of the State Society.

7. Expressions of dissatisfaction have been received, from time to time, respecting policies of the State of Wisconsin General Hospital. In accordance with a recent request of the Columbia County Medical Society referring to this subject, your Secretary will make a separate report at the first meeting of the House of Delegates.

PROGRESS OF MEDICINE

One who reads of the progress in medicine in Wisconsin since the organization of the Society in 1841 must be impressed that in no year might it be said that medicine was not in a period of transition. Truly this is the hallmark of progress. Possibly few appreciate, however, the extent to which the profession has promoted broad, constructive legislation that was purely in the public interest. The care of the insane, the care of the feebleminded, the State Board of Health, laws to protect against quackery,—these and other like enactments came from the organized medical profession of Wisconsin to promote a broad public welfare.

Today, equally with the years past, we have like opportunities for a work of public character that, well done, will reflect not only to the credit but the material benefit of all members of the profession. At such times as these, with outstanding accomplishments already to our credit, it would be easy to fall into the rut of maintaining that gained, becoming so engrossed and concerned therein as to overlook our opportunities for further advancement. It is in accordance with this thought that your Secretary offers the following suggestions for your consideration:

1. Four years ago Councilor R. W. Blumenthal of Milwaukee urged provision for an adequate state inspection and licensing of all hospitals and institutions that house the sick. He ably pointed out that while hospitals are inspected for fire escapes and must be built to conform to fireproof plans laid down by the Industrial Commission, no standards exist to promote the welfare of the patients, or as to staff requirements. The state inspects and licenses barbers and beauty parlor operators, restaurants, plumbers, and well drillers, but anyone may establish a hospital and no one may ask if the patients are receiving reasonable care.

Under the present connection with the Wisconsin Hospital Association, it is suggested that the Secretary be authorized to ascertain whether or not a licensing measure may be drafted for presentation to the 1933 legislature that will meet with their joint approval.

2. Certain organizations in the state, from time to time, have proposed legislation affecting the public health. Such organizations include the Federation of Labor, American Legion, Federation of Womens Clubs, Wisconsin Conference of Social Work, Association for the Care of the Disabled, etc. It would seem probable that the State Medical Society might be helpful to such groups in offering its services in an advisory capacity. Legislation affecting the public health has become a highly specialized and technical subject. Physicians may well be in full accord with ends sought and yet feel constrained to oppose legislation by reason of faulty draftsmanship or inclusion of items, not essential to the purpose, that affect the public and profession adversely. Again, the end sought may be excellent but the legislation may be premature or indeed, not needed at all. It is not suggested that the Society stand as joint sponsors of legislation proposed from other sources but that such contacts be made as will place the services of the Society at the command of any organization interested in the public health to the end that they may have the benefits accruing from the advice of specialists.

Medical leadership, if it be more than an apt phrase, must mean service rendered. As such it may come from the Society direct to the legislature, or indirectly by providing information of value to others who seek to advance the public health. We exercise leadership in the manner first mentioned; it is suggested that we now extend it by serving in an indirect, and possibly even more valuable manner.

THE A. M. A.

In 1933 Chicago is to hold a World's Fair. If the facilities in Milwaukee are approved as adequate by the Trustees of the American Medical Association, and if it is the wish of the Delegates from Milwaukee County, it is suggested that Wisconsin extend a cordial invitation to the Association to hold its 1933 annual meeting in Milwaukee.

CONCLUSION

Other subjects of major importance to the profession and the public at large are being given constant study and special reports will be made from time to time. The routine work of the Secretary has been measurably lightened by the splendid cooperation accorded by the officers and members. Deeply appreciative, it may only be said that criticism and suggestions are ever welcome as a means through which your executive officer may make the Society, so far as it lies within his power, truly representative of the needs and desires of the membership at large.

Respectfully submitted,

GEORGE CROWNHART,
Secretary–Managing Editor.

MEMBERSHIP REPORT

July 1, 1931

County Society	Last Year Dec. 31, 1930	This Year July 1, 1931	Loss— Gain+	Delinquent	Deceased	Removed	New Members	Honorary
1st District—								
Dodge	23	23	--	1	--	--	1	--
Jefferson	30	31	+ 1	1	--	1	3	--
Waukesha	50	47	— 3	5	--	--	2	1
Totals	103	101	— 2	7	--	1	6	1
2nd District—								
Kenosha	41	38	— 3	2	--	2	1	--
Racine	56	62	+ 6	1	--	--	7	--
Walworth	32	26	— 6	7	--	--	1	1
Totals	129	126	— 3	10	--	2	9	1
3rd District—								
Dane	160	152	— 8	8	1	10	11	3
Columbia	31	29	— 2	3	--	--	1	--
Green	15	17	+ 2	--	2	1	5	--
Rock	88	75	—13	8	3	5	3	--
Sauk	19	17	— 2	3	--	1	2	--
Totals	313	290	—23	22	6	17	22	3
4th District—								
Crawford	8	7	— 1	1	--	--	--	--
Grant	33	33	--	1	--	--	1	--
Iowa	13	12	— 1	1	--	--	--	--
Lafayette	13	10	— 3	2	--	1	--	--
Richland	13	12	— 1	1	--	1	1	--
Totals	80	74	— 6	6	--	2	2	--
5th District—								
Calumet	16	13	— 3	2	--	1	--	--
Manitowoc	35	36	+ 1	1	--	1	3	1
Washington-Ozaukee	25	22	— 3	2	--	1	--	--
Sheboygan	55	49	— 6	5	--	2	1	--
Totals	131	120	—11	10	--	5	4	1
6th District—								
Brown-Kewaunee	67	58	— 9	8	--	1	--	1
Door	4	5	+ 1	--	--	--	1	--
Outagamie	43	40	— 3	4	--	3	4	--
Fond du Lac	53	47	— 6	5	--	1	--	--
Winnebago	55	58	+ 3	3	--	--	6	--
Totals	222	208	—14	20	--	5	11	1
7th District—								
Juneau	7	6	— 1	2	--	--	1	--
La Crosse	56	49	— 7	6	1	1	1	3
Monroe	21	16	— 5	2	--	3	--	--
Tremp.-J-B.	20	20	--	--	--	2	2	--
Vernon	12	9	— 3	2	1	--	--	--
Totals	116	100	—16	12	2	6	4	3
8th District—								
Marinette-Florence	23	19	— 4	1	--	3	--	--
Oconto	10	9	— 1	1	--	--	--	--
Shawano	10	10	--	--	1	--	1	--
Totals	43	38	— 5	2	1	3	1	--
9th District—								
Clark	14	11	— 3	2	1	--	--	--
Green Lake-W-A.	15	15	--	--	--	--	--	1
Lincoln	13	13	--	--	--	--	--	--
Marathon	36	37	+ 1	3	--	--	4	--
Portage	20	21	+ 1	--	--	1	2	--
Waupaca	18	15	— 3	5	--	--	2	1
Wood	30	29	— 1	1	--	--	--	--
Totals	146	141	— 5	11	1	1	8	2

County Society	Last Year Dec. 31, 1930	This Year July 1, 1931	Loss— Gain+	Delinquent	Deceased	Removed	New Members	Honorary
10th District—								
Barron-W-S-B	29	26	— 3	2	--	1	--	--
Chippewa	24	23	— 1	2	--	2	3	--
E. Claire & A.	65	61	— 4	4	--	4	4	--
Pier.-St. Croix	27	20	— 7	9	--	--	2	2
Polk	13	13	--	--	--	--	--	--
Totals	158	143	—15	17	--	7	9	2
11th District—								
Ashland B-I.	23	21	— 2	1	1	--	--	--
Douglas	37	31	— 6	6	--	--	--	--
Oneida-F-V	13	12	— 1	1	--	--	--	--
Price-Taylor	11	9	— 2	1	--	1	--	--
Totals	84	73	—11	9	1	1	--	--
12th District—								
Milwaukee	670	570	—100	90	6	24	20	--
Gr. Total	2195	1984	—211	216	17	74	96	14

AUDITOR'S REPORT

June 10, 1931.

To the Board of Councilors of the State Medical Society of Wisconsin and the Editorial Board of the Wisconsin Medical Journal

Dear Sirs:

Complying with the request of Mr. J. George Crownhart, Secretary and Managing Editor of your respective bodies, we have made a cash audit of the financial records of the two organizations, and submit herewith our report consisting of the Exhibits and Schedules enumerated below, which, in our opinion, sets forth a proper accounting of all moneys entrusted to Mr. Crownhart during the year examined.

The Wisconsin Medical Journal

Exhibit A—Balance Sheet as of December 31, 1930.
Exhibit B—A Statement of Revenues and Expenses for the year ended December 31, 1930.
Schedule A-1—Reconciliation of Account at Commercial National Bank at December 31, 1930.
Schedule A-2—A Schedule of Accounts Receivable at December 31, 1930.

The State Medical Society of Wisconsin

Exhibit C—Statement of Receipts and Disbursements for the year ended December 31, 1930.
Schedule C-1—Analysis and Reconciliation of the Checking Account at the Commercial National Bank for year ended December 31, 1930.
Schedule C-2—Analysis and Reconciliation of Advance Dues Account at the Commercial National Bank for year ended December 31, 1930.

Verification of the cash in the bank at December 31st of each organization was accomplished by direct correspondence with the depository. All receipts recorded on the books of the respective organizations were proved with the deposits in the corresponding bank accounts.

The disbursements of the Wisconsin Medical Journal were checked against invoices or vouchers and with the exception of disbursements for salaries and other incidental items, relatively small in amount, the disbursements were properly vouched.

The disbursements of the State Medical Society of Wisconsin are not authorized by vouchers, but consist principally of remittances of the Secretary to Dr. Rock Sleyster, Treasurer of the Society. Remittances, accompanied by a remittance statement, are forwarded periodically to the Treasurer, who signs and acknowledges receipt thereof and returns the receipted form to the Secretary. Such signed receipts of the Treasurer were found supporting each remittance by the Secretary. Other disbursements amounting to $84.50 were made to local secretaries refunding overpayment of dues. The cancelled checks covering these disbursements were examined. One check of $3.00 was issued payable to the Wisconsin Medical Journal to reimburse the Journal for an error made in depositing a Journal check in the Society's account.

We examined the receipt stubs from which receipts were issued to local secretaries or others in acknowledgment of dues received and checked these amounts with the dues recorded in the cash book. The total receipts for dues, applicable to the year 1930, as listed in the cash book was $24,355.25. Of this total $3,038.00 was collected in 1929 and segregated in a special bank account known as "Advance Dues" and $21,317.25 was received in payment of 1930 dues during the current year. The sum of these two items was remitted to the Treasurer of the Society during the year for which the Secretary holds receipts. The object in segregating and withholding dues paid in advance is to make possible from year to year a comparison of the Society's income from this source.

Respectfully submitted,
MAC GOWAN & TAYLOR,
Auditors and Public Accountants.

Exhibit A

THE WISCONSIN MEDICAL JOURNAL
Madison, Wisconsin

Balance Sheet as of December 31, 1930

ASSETS		
Current Assets		
Cash in Bank (Schedule A-1)	$1,469.51	
Accounts Receivable (Schedule A-2)	1,603.58	
Total Current Assets		$3,073.09
Investments		
The Milwaukee Gas Light Company 4¼% Bond due March 1, 1967		975.00
Fixed Assets		
Office Equipment	$98.00	
Allowance for Depreciation	19.60	
Total Fixed Assets		78.40

Prepaid Expense		
Postage Deposit		58.57
Total Assets		$4,185.06

LIABILITIES AND SURPLUS

Current Liabilities		None
Surplus		
Balance, January 1, 1930	$4,384.51	
Deduct: Net Loss for 1930 (Exhibit B)	199.45	
Balance, December 31, 1930		4,185.06
Total Liabilities and Surplus		$4,185.06

Exhibit B

THE WISCONSIN MEDICAL JOURNAL
Madison, Wisconsin

A Statement of Revenues and Expenses For Year Ended December 31, 1930

REVENUES		
Advertising Revenue		$9,212.14
Subscription Revenue		160.90
Interest Received		27.00
Miscellaneous Revenue		6.00
Total Revenue		$9,406.04
EXPENSES		
Printing	$6,806.11	
Salaries	1,571.21	
Cuts	384.05	
Rent	300.00	
Mailing	224.02	
Legal and Accounting	195.00	
Discounts Allowed	45.30	
Miscellaneous Expense	45.00	
Bad Accounts, charged off	25.00	
Depreciation	9.80	
Total Expense		9,605.49
Net Loss for Year		$199.45

Schedule A–1

THE WISCONSIN MEDICAL JOURNAL
Madison, Wisconsin

Reconciliation of Account With Commercial National Bank, December 31, 1930

Balance, December 31, 1930, as certified by the depository		$1,478.51
#90—May 7, 1929 to Dr. C. H. Dodge	$.50	
282—Dec. 30, 1930 to Moore-Cottrell Company	7.55	
283—Dec. 30, 1930 to Dr. A. H. Heidner	.70	
284—Dec. 30, 1930 to Ellinore Beck	.25	9.00
Balance, December 31, 1930—Exhibit A		$1,469.51

Verification of Cash in Bank December 31, 1930

Cash in Bank, January 1, 1930	$3,408.66	
Add:		
Total Receipts deposited	8,954.57	
To Cash to be accounted for		$12,363.23
Deduct:		
Checks, numbers 173 to 284, inclusive, issued during 1930		10,893.72
Cash in Bank, December 31, 1930		$1,469.51

Schedule A–2

THE WISCONSIN MEDICAL JOURNAL
Madison, Wisconsin

Schedule of Accounts Receivable December 31, 1930

Anderson Bureau	$90.00
Benson Optical Company	22.50
Bureau of Home Nursing	3.00
C. M. A. B.	298.58
Doerflinger Artificial Limb Company	12.50
Ev. Deaconess Hospital	16.00
First Wisconsin Company	22.50
Dr. C. A. H. Fortier	22.50
Morris F. Fox & Company	22.50
Gosin Clinic	8.00
Karrer Company	135.00
Kremers–Urban Company	12.50
Madison Sanitarium	101.25
The Manse	11.25
Marquette University	22.50
Mellin's Food Company	22.50
Milwaukee Optical Mfg. Company	75.00
Milwaukee Sanitarium	36.00
W. J. MacKellar	58.50
Normandale	90.00
Oconomowoc Health Resort	90.00
Orthopedic Appliance Company	12.50
Pengelly X-Ray Company	50.00
River Pines Sanatorium	15.00
Shorewood Hospital-Sanitarium	36.00
Stokes' Sanatorium	20.00
Seelman Laboratories	135.00
Summit Hospital	40.00
Snow Flyer	18.00
Dr. E. L. Tharinger	12.50
Thatcher Laboratories	45.00
The Waukesha Spa, Inc.	12.50
Waukesha Springs Sanitarium	90.00
Roger Williams Hospital	22.50
Debit Balances	$1,681.58
University of Wisconsin—Credit Balance	78.00
Accounts Receivable—Exhibit A	$1,603.58

Exhibit C

THE STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin

A Statement of Receipts and Disbursements For the Year Ended December 31, 1930

Cash in Bank, January 1, 1930, consisting of		
Checking Account Balance		$100.00
Advance Dues (for 1930, received during 1929)		3,038.00
Total Cash in Bank, January 1, 1930		$3,138.00
Receipts		
1930 Dues Collected	$21,401.75	
1931 Advance Dues Collected	281.00	

Check payable to Wisconsin Medical Journal deposited in error	3.00	
Total Receipts		21,685.75
Total Cash to be Accounted for		$24,823.75
Disbursements		
1930 Dues remitted to Treasurer	$24,355.25	
Refund to local secretaries	84.50	
Reimbursing Wisconsin Medical Journal for check deposited in error	3.00	
Total Disbursements		24,442.75
Cash in Bank, December 31, 1930, consisting of:		$381.00
Checking Account Balance		$100.00
1931 Advance Dues		281.00
Total		$381.00

Schedule C–1

THE STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin

Analysis of Deposits and Withdrawals—Checking Account at the Commercial National Bank For Year Ended December 31, 1930

Balance, January 1, 1930		$100.00
Deposits during year		
1930 Advance Dues transferred from Advance Dues Account, January 6	$3,038.00	
1930 Dues	21,401.75	
Check payable to Wisconsin Medical Journal deposited in error	3.00	
Check redeposited after proper endorsement	12.00	
Total Deposits for the Year		24,454.75
Total Cash to be accounted for		$24,554.75
Withdrawals for the year		
By Checks to Dr. Rock Sleyster, Treasurer	$24,355.25	
By Checks to local secretaries	84.50	
By Checks to Wisconsin Medical Journal	3.00	
By Bank Debit Memorandum	12.00	
Total Withdrawals for the year		24,454.75
Balance, December 31, 1930, subject to withdrawal		$100.00

Reconciliation of Checking Account at Commercial National Bank at December 31, 1930

Balance, December 31, 1930, as certified by the Commercial National Bank	$110.00
Less: Checks Outstanding	
#70 dated Dec. 29, 1930 to Dr. Rock Sleyster	10.00
Balance, December 31, 1930	$100.00

Schedule C–2

THE STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin

Analysis of Deposits and Withdrawals—Advance Dues Account at the Commercial National Bank For the Year Ended December 31, 1930

Balance, January 1, 1930	$3,038.00
Deposits during year	
1931 Advance Dues, collected in 1930	281.00
Total Cash to be accounted for	$3,319.00
Withdrawals	
January 1st balance transferred and deposited in Checking Account January 6th	3,038.00
Balance, December 31, 1930	$281.00

Reconciliation of Advance Dues Account at the Commercial National Bank at December 31, 1930

Balance, December 31, 1930 as certified by Commercial National Bank	$281.00

REPORT OF THE TREASURER

To the 1931 House of Delegates:

There is submitted herewith the report of the auditors for the calendar year ending December 31, 1930. The budget for the current year was published in the Wisconsin Medical Journal for February, 1931, and is represented in this issue under the report of the Chairman of the Council.

Respectfully submitted,

ROCK SLEYSTER,
Treasurer.

PACE, GORE & MCLAREN
Accountants and Auditors

Milwaukee, Wisconsin, February 25, 1931.

Board of Councilors,
The State Medical Society of Wisconsin,
Madison, Wisconsin.
Gentlemen:

We have audited the accounts and financial records of Dr. Rock Sleyster, Treasurer, The State Medical Society of Wisconsin, for the year ended December 31, 1930, and in our opinion the appended statement of cash receipts and disbursements presents a correct accounting of the Society's funds entrusted to Dr. Sleyster's care for the year under review.

The cash in bank was verified by a certificate from the depository reconciled with the balance as

shown by the books. All receipts recorded on the books were traced into the bank and we made a test-check of the remittance advices of your Secretary with cash receipts as shown on the books.

Cash disbursements were verified by comparison with vouchers on file.

The investment securities as listed in exhibit B were presented for our inspection, and are carried on the books at par. The interest thereon was received and deposited in the bank.

Yours very truly,

PACE, GORE & MCLAREN.

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS

Year Ended December 31, 1930

DR. ROCK SLEYSTER, TREASURER
The State Medical Society of Wisconsin

	General Fund		Medical Defense Fund		Total	
CASH IN BANK, JANUARY 1, 1930		$ 140.18		$ 186.03		$ 326.21
RECEIPTS:						
Remittances from J. G. Crownhart, Secretary	$21,692.75		$2,740.00		$24,432.75	
Exhibit rentals	2,139.32				2,139.32	
Miscellaneous	166.48				166.48	
Interest on bonds	1,021.00		240.00		1,261.00	
Interest on certificate of deposit	56.71				56.71	
Certificate of deposit cashed	5,000.00				5,000.00	
Total receipts		30,076.26		2,980.00		33,056.26
Total cash to be accounted for		30,216.44		3,166.03		33,382.47
DISBURSEMENTS:						
Salaries	10,248.67				10,248.67	
News service	2,275.00				2,275.00	
Rent of office	640.00				640.00	
Printing, stationery and postage	1,882.12				1,882.12	
Office supplies and expense	228.94				228.94	
Traveling expense	1,214.06				1,214.06	
Annual and other meetings	5,175.29				5,175.29	
Attorney fees	1,299.23		1,215.77		2,515.00	
Telephone and telegraph	373.62				373.62	
Wisconsin Anti-Tuberculosis Association	300.00				300.00	
Books and periodicals	360.90				360.90	
Insurance	64.50				64.50	
Refund	12.00				12.00	
Miscellaneous	795.86				795.86	
Accrued interest on bonds purchased	28.80				28.80	
Premium and brokerage on bonds purchased	67.00				67.00	
Certificate of deposit purchased	5,000.00				5,000.00	
		29,965.99		1,215.77		31,181.76
CASH IN BANK, DECEMBER 31, 1930		$ 250.45		$1,950.26		$ 2,200.71

SUMMARY OF FUNDS

GENERAL FUND:		
Bank balance, December 31, 1930	$ 250.45	
Investment securities	20,000.00	
		$20,250.45
MEDICAL DEFENSE FUND:		
Bank balance, December 31, 1930	1,950.26	
Investment securities	5,000.00	
		6,950.26
Total funds		$27,200.71

INVESTMENT SECURITIES

December 31, 1930

GENERAL FUND:	Rate	Number	Due Date	Par Value
Northern States Power Co., first and refunding mtg. gold bond series A	5%	D471	Apr. 1, 1941	$ 500.00
Northern States Power Co., first and refunding mtg. gold bond series A	5	707	"	500.00
Northern States Power Co., first and refunding mtg. gold bond series A	5	1252	"	500.00
Northern States Power Co., first and refunding mtg. gold bond series A	5	1253	"	500.00
Northern States Power Co., first and refunding mtg. gold bond series A	5	1372	"	500.00
Northern States Power Co., first and refunding mtg. gold bond series A	5	1427	"	500.00
Northern States Power Co., first and refunding mtg. gold bond series A	5	1534	"	500.00
Northern States Power Co., first and refunding mtg. gold bond series A	5	1651	"	500.00
American Telephone & Telegraph Co., convertible gold bonds	4	101541	Mar. 1, 1936	1,000.00
" "	4	101542	"	1,000.00
" "	4	101544	"	1,000.00
" "	4	101545	"	1,000.00
Wisconsin Public Service Co., first mortgage and refunding gold bonds series A	5	770	Jan. 1, 1942	1,000.00

Wisconsin Public Service Co., first mortgage and refunding gold bonds series A	5	1777	"	1,000.00
Wisconsin Public Service Co., first mortgage and refunding gold bonds series A	5	2198	"	1,000.00
The Milwaukee Electric Ry. & Lt. Co., first and refunding bonds series B	5	M8137	June 1, 1961	1,000.00
The Milwaukee Electric Ry. & Lt. Co., first and refunding bonds series B	5	M41687	"	1,000.00
Milwaukee Gas Light Co., first mortgage bonds	4½	M8563	May 1, 1967	1,000.00
" "	4½	M8564	"	1,000.00
Canadian National Railway Co., guaranteed gold bonds	5	M41899	Oct. 1, 1969	1,000.00
" "	5	M41890	"	1,000.00
Wisconsin Traction, Light, Heat & Power Co., first mortgage bonds	5	276	July 1, 1931	1,000.00
Wisconsin Traction, Light, Heat & Power Co., first mortgage bonds	5	754	"	1,000.00
Wisconsin Traction, Light, Heat & Power Co., first mortgage bonds	5	2737	"	1,000.00
				$20,000.00
MEDICAL DEFENSE FUND:				
Commonwealth Edison Co., first collateral bonds series D	4½	M2202	July 1, 1957	$ 1,000.00
" "	4½	M12267	"	1,000.00
Pacific Telephone & Telegraph Co., first and collateral trust sinking fund bonds	5	21945	Jan. 2, 1937	1,000.00
Bell Telephone Company of Canada, first mortgage bonds series A	5	M00652	Mar. 1, 1955	1,000.00
Bell Telephone Company of Canada, first mortgage bonds series A	5	M00653	"	1,000.00
				$ 5,000.00

COMMITTEE ON PUBLIC POLICY

To the 1931 House of Delegates:

It is a source of pleasure to report that at the conclusion of the legislative session no proposal had passed that was opposed by your State Society. On the other hand, two of the three major proposals made by the Society are now laws of the State.

Your committee would presently suggest that authority be granted to introduce at the subsequent session the following measures:

1. Provide for a physician member on the County Health Committee that supervises the work of the County Nurse.
2. Provide for a physician member of health committees in cities.

The committee refers to the House for instructions the following matters:

1. Shall the committee re-introduce the bill providing for a medical grievance committee (see addenda 1)?
2. Shall the Committee re-introduce the bill providing for removing certain restrictions upon the Governor in making appointments to the State Board of Medical Examiners (see addenda 2 and Wisconsin Medical Journal for May, 1931, page 381 ff.)

The committee report upon 1931 legislation as of July first follows:

35, S.—Unamended this bill would have joined insurance companies as parties defendant in malpractice actions thereby operating greatly to increase the number of malpractice actions. Amendment to exempt physicians, surgeons, and dentists secured.

58, S.—Would have created a state medical grievance committee. Killed in the Senate.

150, S.—Defining unethical practices of optometrists and providing a penalty. A law.

252, S.—Relating to poor relief. As originally drafted, this bill would have worked serious injuries to the medical profession. Changes offered by the profession were adopted. Killed in Assembly.

348, S.—Narrowing the store exemption for the sale of glasses under the optometry law. A law.

Budget—Continues appropriation of $5,000 annually for full time investigator to weed out quackery. Investigator transferred to State Board of Health. A law.

Budget—Provision that fees shall be charged physicians for laboratory examinations at Psychiatric Institute and Laboratory of Hygiene. Estimated to raise $60,000 annually from physicians. Vetoed by Governor.

71, A.—Abolished panel system for physicians under Compensation Act. Authorized Industrial Commission to establish schedule of fees. Provided for treatment by chiropractors. Passed in Assembly. Killed in Senate.

89, A.—Prohibited testimony of physicians before Industrial Commission unless reports of physician to insurer, have also been made to injured workmen, except that where reports are of kind that should not be made to injured person such reports shall be made to Industrial Commission. Provided for examination by physician chosen by employe at expense of employer if panel physician failed to render reports to injured workman. Passed Assembly. Killed in Senate.

90, A.—Provides time and a half wages for employees who exceed eight hours a day. Amendment to exempt institutions caring for the sick adopted.

155, A.—Provided for a medical examiner for Milwaukee County to supersede services of Coroner. Opposed by Medical Society of Milwaukee County. Killed in Assembly.

178, A.—Anti-vivisection bill applicable to dogs only. Introduced by request of Wisconsin Anti-vivisection Society. Killed in Assembly, 87 to 1.

182, A.—Amendment to State Hospital law providing that in cases that can be cared for equally well at home at equal or lesser expense to county, the County Judge may authorize local care in any institution within the county. A law.

267, A.—Substantially the same as 35, S. Amendment to exempt physicians, surgeons, and dentists adopted. Bill killed in favor of 35, S.

345, A.—Changing requirements upon Governor in appointments to State Board of Medical Examiners from two eclectics, two homeopaths, three allopaths, and one osteopath to one osteopath and "seven licensed to practice medicine and surgery." Killed in Assembly.

497, A. Unless employer files objections with Industrial Commission, injured employees may secure chiropractic treatment under the Compensation Act. Passes in Assembly and Senate. Vetoed by Governor.

580, A.—Would have revised county health committees including a physician on the Committee. Killed in Assembly, probably because of the complete revision rather than because of adding a physician.

729, A.—Authorized an interim committee of the Legislature with broad powers to investigate the subject of health, accident and industrial insurance. Passed Assembly. Killed in Senate.

852, A.—Would license nurses in industrial plants to practice medicine for employees and their families except for prescribing drugs containing narcotics or liquors. Killed in Assembly.

892, A.—Would have permitted chiropractors and optometrists to have conducted examinations of school children. Passed in Assembly. Killed in Senate.

945, A.—Providing for centralization of all examining boards. By faulty drafting, the bill would repeal the Basic Science Act of 1925. Bill finally withdrawn as session closed.

Respectfully submitted,

OTHO A. FIEDLER, Sheboygan, *Chairman.*
S. M. B. SMITH, Wausau.
CARL S. HARPER, Madison.
And the Secretary.

Addenda I

A BILL

To create sections 147.195 and 20.445 of the statutes, relating to the state medical grievance committee, and making an appropriation.

The people of the state of Wisconsin, represented in senate and assembly do enact as follows:

Section 1. Sections 147.195 and 20.445 of the statutes are created, to read: 147.195 The state health officer, the secretary of the state board of medical examiners, and the attorney general or deputy attorney general are hereby constituted ex-officio a state medical grievance committee to investigate, hear, and act upon practices by persons licensed to practice medicine and surgery under section 147.17, that are inimical to the public health. The state health officer shall be chairman of the committee. Meetings of the committee shall be held at the call of the chairman. Any member thereof shall have power to subpoena and swear witnesses, and take evidence. The committee shall have power to warn and to reprimand, when they find such practice, and to institute criminal action or action to revoke license when they find also probable cause therefor under criminal or revocation statute, and the attorney general may aid the district attorney in the prosecution thereof. The records of said committee shall be kept by and be in the custody of the chairman thereof. No member of said committee shall receive any extra compensation therefor, nor other than his actual expenditures in attending upon his duties thereon.

20.445 To the state medical grievance committee, such sums as may be necessary to carry out the provisions of section 147.195.

Section 2. This act shall take effect upon passage and publication.

Addenda II

A BILL

To amend subsection (1) of section 147.13 of the statutes, relating to the state board of medical examiners.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

Section 1. Subsection (1) of section 147.13 of the statutes is amended to read: (147.13) (1) The governor shall appoint the "Wisconsin State Board of Medical Examiners," consisting of eight members. The appointment of each member shall be for four years. No instructor, stockholder, member of, or person financially interested in any school, college or university having a medical department, or of any school of osteopathy, shall be eligible. (Three members shall be allopathic, two homeopathic, two eclectic and one osteopathic, and all shall be licentiates of the board.) *Seven members shall be practitioners of medicine and surgery and one member shall be a practitioner of osteopathy, and all shall be licensed under section 147.17.*

Section 2. This act shall take effect upon passage and publication, except that it shall not shorten the term of any present member of said board.

COMMITTEE ON MEDICAL DEFENSE

To the 1931 House of Delegates:

I am pleased to report that during the past year your Society has been unusually favored: the smallest number of cases in its history has been referred to it for defense. A total of 7 cases compares very favorably with the large number which has, in the past, come to our notice. Of these 7, four are in the hands of other protective organizations, and will in all likelihood be conducted with our attor-

ney as counsel only; one was settled at a very nominal figure through an insurance carrier; two have not been reported upon since first notice of suit was posted. In addition to the above 7, there were two who were threatened, but no further action taken.

With the exception of one hotly contested case which we requested Mr. Hoyt to carry to a conclusion because he had had the conduct of it for some time previously, Mr. R. R. Freeman, who was mentioned in last year's report as having succeeded Mr. Ralph Hoyt as our counsel, has taken active hold of all the work that has been referred to him, and we are indeed happy that so satisfactory a professional connection could be made.

It has not yet been possible to publish letters of advice from our counsel, or analyses of cases that should act as object lessons, as was promised our subscribers last year. We are, however, continuing our efforts to this end, and trust these proposed "lessons" may be forthcoming during the coming winter.

During a recent visit in Philadelphia your Secretary learned that a much more formal method of applying for medical defense is being used in Pennsylvania. This plan has some features that we may copy with profit, and it will be our endeavor to formulate a working plan to be presented at next year's meeting of the Society.

ARTHUR J. PATEK, *Chairman.*

HEALTH AND PUBLIC INSTRUCTION

To the 1931 House of Delegates:

Your Committee on Health and Public Instruction, which also acts as a special committee on cancer, has during the past year carried on certain lay educational work in general disease prevention and hygiene and some special work on cancer. The cancer work is done in cooperation with the American Association for the Prevention of Cancer.

To enumerate: We have presented some two hundred subscriptions to Hygeia to members of the legislature, state officers, libraries of state teachers colleges, and some prominent laymen, including editors. We also presented about one hundred copies of Paul De Kruif's "Microbe Hunters" to members of the legislature. Cancer control has been discussed before lay audiences of men and women in many parts of the state. These talks have been given to women's clubs, civics and luncheon clubs. Through the Federated Women's Clubs literature on the control of cancer has been distributed. This was accomplished through the cooperation of the American Association for the Prevention of Cancer.

The committee has felt that because of the widespread and intensive lay educational campaign on cancer that the public is being lead to expect more of the medical profession in the way of cancer control than our present state of knowledge and organization warrants. We, therefore, have secured the cooperation of the American Association for the Prevention of Cancer in making a survey of the facilities in the State for the diagnosis and treatment of cancer cases. The Association has generously agreed to send an experienced physician to Wisconsin to start this survey in July. The results of his work will be reported to the medical society with recommendations for improvement of our service to cancer patients.

Because of the changing conditions in the diagnosis and treatment of cancer and because we have felt the necessity of presenting to the physicians of the State, particularly the surgeons, the importance of this change, we have arranged a scientific exhibit on cancer for the meeting of the State Medical Society in September and for a cancer clinic to be held by Dr. Joseph Bloodgood of Baltimore.

W. D. STOVALL, *Chairman,*
C. M. GLEASON,
H. M. STANG.

COMMITTEE ON NECROLOGY

To the 1931 House of Delegates:

The Council, as the Committee on Necrology, has to report to this House the deaths of the following physicians during the year past (members of the Society are indicated by bold face type):

Albers, H. H. ---------- Allenton
Allen, George D. ---------- Belleville
Andrew, G. F. ---------- De Soto
Andrus, A. P. ---------- Ashland
Baer, A. N. ---------- Milwaukee
Bernhard, A. ---------- Milwaukee
Bours, Thomas R. ---------- Milwaukee
Bradfield, J. A. L. ---------- La Crosse
Cargill, Nellie W. ---------- Milwaukee
Clark, R. B. ---------- Monroe
Connell, D. R. ---------- Beloit
Daniels, A D. ---------- Rhinelander
Dietrich, L. S. ---------- Stevens Point
Dwight, C. G. ---------- Madison
Elmergreen, Ralph ---------- Milwaukee
Galford, G. H. ---------- Ashland
Gates, G. H. ---------- Milwaukee
Gilfrey, R. A. ---------- Milwaukee
Golley, F. B. ---------- Milwaukee
Harbert, Helen A. ---------- Kenosha
Harrison, David C. ---------- Mason
Hill, L. B. ---------- Baraboo
Hodges, F. L. ---------- Monroe
Ide, Charles E. ---------- Milwaukee
Johnston, G. B. ----------Abbotsford
Kaetel, C. H. ---------- Milwaukee
Kenney, George F. ---------- Milwaukee
Lucast, Thomas ---------- Birnamwood
MacLaughlin, Harry E. ---------- Waupaca
Martin, Marshall T. ---------- Madison
Moeller, John ---------- Milwaukee
Mork, Ole ---------- Blair
Morris, E. K. ---------- Merrill
Morse, E. A. ---------- Appleton
Noer, P. J. ---------- Wabeno

Nott, G. W. ---------- Racine
Prees, G. W. ---------- Cambria
Purtell, E. J. ---------- Milwaukee
Rowles, J. A. ---------- La Crosse
Ryan D. J. ---------- Neenah
Sattler, John M. ---------- Milwaukee
Sauthoff, Mary ---------- Mendota
Schneider, F. ---------- New London
Seidel, J. G. ---------- Warrens
Shaw, J. L. ---------- Manitowoc
Shepherd, W. A. ---------- Seymour
Thorne, J. P. ---------- Janesville
Wheeler, C. E. ---------- Milwaukee
Wiltrout, I. D. ---------- Chippewa Falls
Wooll, Gerald K. ---------- Janesville
Young, George H. ---------- Elkhorn

Respectfully submitted,
THE COUNCIL,
J. G. CROWNHART, *Secretary.*

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

To the 1931 House of Delegates:

Medical Education: At Marquette new policies in method of instruction are announced. (1) During the year 1930–31 orientation conferences for first and second year medical students were inaugurated. These conferences are under the direction of members of the clinical faculty and are attended also by members of the faculty of the basic sciences. The aim is to stress the correlation between the basic sciences and clinical and preventive medicine. (2) Beginning with the year 1931–32 the subject system is to replace the class system. Promotion is to depend rather upon mastering departments of knowledge than upon completing a fixed curriculum in a given time. (3) Clinical laboratory work is expanded for third and fourth year medical students so as to embrace anatomy and physiology as applied to medical diagnosis and therapy. This work will supplement the laboratory work long successfully conducted as a basis for clinical surgery. (4) The fourth year class is divided into sections so as to take advantage of the clinical facilities offered by the County Hospital and the various other institutions in which clinical instruction is given. The practical work of the students is largely individual or in small groups under supervision of members of the clinical faculty.

The State University is continuing its preceptor system for the instruction of fourth year medical students. One quarter of the fourth year is now spent by each student in Milwaukee and this Milwaukee quarter under the preceptor plan has proved of great value in giving the student insight into the medical problems presented by a larger city.

Over-standardization in medical education is giving way to an endeavor to adapt the work of the institution to its natural advantages. This endeavor is meeting with success in both of our medical schools.

Medical Extension: During the past year a special course on insulin was given with success in six different centers. A special course on nose and throat, with particular emphasis on the larynx was given by Dr. Franz Hasslinger of Vienna during June and two circuits on obstetrics were conducted during the summer months. Although the special provision for medical extension, used largely for medical extension library work, was vetoed in the budget, arrangements have been made to continue this work.

Hospitals: The new Milwaukee County hospital contains 660 beds and together with the old county hospital forms a unit of 1,000 beds. The Milwaukee County Dispensary now cares for over 80,000 patients per year.. The Emergency Unit connected with the Dispensary has fifty beds. The authorities in charge of these institutions and of Muirdale, the county tuberculosis sanatorium, maintain a liberal attitude toward medical education.

The most notable recent addition to public hospitals in the State, aside from the Milwaukee County institutions, is the State Orthopedic Hospital for Children on the university campus. This hospital will have about 125 beds for orthopedic patients under 21 years of age. The Milwaukee Children's Hospital, a public institution under private auspices, has recently completed a beautiful convalescent hospital at Wauwatosa and is making extensive additions to its main building.

Among the more notable of public hospitals recently completed, special mention may be made of that at Antigo.

The State Board of Control and the special committee on Crime and Criminal Justice of the State Conference of Social Work have both stressed the great need of better hospital facilities at the state institutions, especially at the state prison at Waupun.

C. R. BARDEEN, *Chairman.*
J. W. LAMBERT,
F. D. MURPHY.

MEDICAL EXTENSION

To the 1931 House of Delegates:

The Society's program of postgraduate medical instruction, given annually in Wisconsin since 1928, reached in the year closing on June 30 the point of its highest success. In number of lecture courses given and in total enrollments a new mark was set. Three courses were given in their entirety and a fourth started. The latter, covering Obstetrics and Gynecology, will continue through the summer as a part of the coming year's program.

The medical program also embraces the Medical Library Service and the extra-mural lectures at county medical societies, each of which is described briefly in this report.

The year's curriculum included courses in Internal Medicine, Insulin and Its Use, Clinical Larynx, and

Obstetrics and Gynecology. The total enrollment was 630 physicians.

The University of Wisconsin Medical School collaborated in selecting instructors and centers. The organization of the courses was done by the University Extension Division. Its field staff devoted much time to enrollments.

THE POSTGRADUATE PROGRAM

Facts and figures about the year's program, given below, show the extent of this medical extension service as developed in Wisconsin in recent months:

Course in Internal Medicine, First series (for central and southern Wisconsin), June 23 to September 13, 1930: Instructors, Dr. Ralph A. Major, Professor of Medicine, University of Kansas, and Dr. John H. Musser, Professor of Medicine, Tulane University.

Enrollment: Beloit, 17; Janesville, 10; Madison, 16; Beaver Dam, 14; Fond du Lac, 26; Watertown, 19 total, 102.

Second series (for north-central Wisconsin), June 30 to September 20, 1930: Instructors: Dr. M. A. Blankenhorn and Dr. Roscoe D. Leas, Professors of Medicine, Western Reserve University.

Enrollment: Antigo, 13 Marshfield, 19; New London, 9; Rhinelander, 9; Stevens Point, 21; Wausau, 17; total, 88.

Total enrollment, both series, 190.

Course in Insulin and Its Use (for the state at large), May 18–23, 1931: Instructors, Dr. L. S. McKittrick, Harvard University; Dr. R. M. Wilder, University of Chicago, and Dr. E. L. Sevringhaus, University of Wisconsin.

Enrollment: Madison, 40; Oshkosh, 53; Milwaukee, 70; Wausau, 55; Eau Claire, 52; La Crosse, 39; total, 309.

Course in the Clinical Larynx, June 23–27, 1931: Instructor, Dr. Franz Haslinger, Hajek Clinic, Vienna, Austria. Headquarters, Service Memorial Institutes, Madison. Enrollment, 18.

The course in Obstetrics and Gynecology got under way on June 15 and will continue until September 5 at weekly centers in six cities in northeastern Wisconsin. The instructors are Dr. Everett D. Plass, University of Iowa, and Dr. Otto H. Schwarz, Washington University, St. Louis, Mo.

The enrollment follows: Manitowoc, 19; Oshkosh, 20; Sheboygan, 20; Appleton, 13; Green Bay, 27; Marinette, 14; total, 113.

The course in Insulin for physicians was made the means of extending valuable instruction to the lay public in the characteristics of diabetes and the proper use of insulin in the home. This was especially pertinent for those having responsibility for diabetic patients at home. In each city where the clinical course was given in the daytime, Dr. Sevringhaus gave a free public lecture in the evening. The attendance by these non-professional groups was as follows: Madison, 90; Oshkosh, 110; Milwaukee, 300; Wausau, 175; Eau Claire, 160; La Crosse, 80; total, 915.

The course in the Clinical Larynx was organized in May on short notice, yet eighteen specialists in this field from many parts of the state were enlisted in the five-day intensive course given in Madison. Dr. Haslinger, one of Europe's noted authorities on throat diseases, fulfilled all expectations in presenting his subject scientifically and lucidly. The instruction was made the more practical by the use of phantoms of his own expert design.

All physicians who took this course recorded in writing their approval of its content and of Dr. Haslinger's "excellent method of presentation," and urged the University Extension Division to provide a similar course in another year.

These lecture courses are part of an eight-year Medical Extension program to bring the advantages of postgraduate instruction to the home districts of Wisconsin physicians. Next year's curriculum is planned to include courses in Obstetrics and Pediatrics. Obstetrics is suggested to be given in the western circuit with centers of instruction at La Crosse, Monroe, Portage, Platteville, Richland Center, and Tomah. Pediatrics is tentatively scheduled for the southeastern district, with meetings at Burlington, Kenosha, Milwaukee (two courses), Racine, and Waukesha.

MEDICAL LIBRARY SERVICE

The general popularity which has characterized the use of the Medical Library Service each year from its beginning continued in the past year, according to Miss Frances van Zandt, the librarian. Both in the requests for informational material and in loans of books and periodicals, the Library Service was drawn upon by an ever growing number of physicians who appreciated the unique professional advantage afforded by their free access to current medical literature and to the 40,000 volumes in the Medical School library.

It ceased long since to be possible (if indeed it ever were possible) for one physician to buy and shelve all the literature which he needs or with which he should be familiar. His need has been fully met, however, by the Medical Library Service, a unit of the University Extension Division operated in connection with the Medical School and enjoying a close affiliation with the State Medical Society.

Those who probably appreciate best the medical library facilities are physicians listed as "regulars." Physicians thus classified obtain each issue of a selected journal as soon as the library receives it from the publishers; the only obligation is five cents plus postage. For book packages the charge is postage both ways and the wrapping cost.

Having a record of the periodical desired regularly by the physician, the library sends it each week, month, or quarter, as the case may be, thus freeing the physician and the librarian of the trouble of handling a special request for each number. In the case of periodicals in much demand by many physicians, the library subscribes for enough

copies to serve the group, thus reducing the waiting list to a minimum.

An indication of the extensive scope of this service is the fact that the library now supplies these "regulars" with 139 different professional and scientific publications. Altogether, the library has on file 174 periodicals to meet all types of loans.

During the past year 54 Madison and 68 Milwaukee physicians, and 319 from other Wisconsin communities, a total of 441 physicians, made use of the Medical Library Service. Their requests for informational material were filled 5,566 times, and their loans of books and periodicals were 8,367. Each number represented a slight decrease from the previous year.

The months of highest loans and the numbers of loans in those months during each year of the Medical Library's operations are shown in the following table:

1927–28	April	307
1928–29	January	706
1929–30	March	1,167
1930–31	November	888

COUNTY SOCIETY LECTURES

The extra-mural medical lectures by members of the Wisconsin General Hospital staff were continued during the year. Fifty speakers were supplied to county medical societies. Each assignment was made with a recognition of the speaker's competency to present his subject as a specialist in his field. Invariably the lectures were illustrated with visual aids or other supplementary means of making the presentation of unusual value to the profession represented in the meetings of the county societies.

CHESTER D. SNELL, *Dean,*
For the Advisory Committee on Medical Extension.

DELEGATE TO AMERICAN MEDICAL ASSOCIATION

Scientific Sessions

To the 1931 House of Delegates:

The 82nd annual session of the American Medical Association held at Philadelphia on June 8–12, 1931 was well attended, with a registration on Monday of 2060; on Tuesday a further registration of 1760; on Wednesday 2104; and on Thursday 904, making a total for the four days of 6828.

The meetings of the House of Delegates were held in the Benjamin Franklin Hotel as headquarters, and the scientific assembly, the scientific exhibit, and technical exhibit were held in the new Municipal Auditorium at 34th Street. Four floors of the Municipal Auditorium were used, making it very convenient with the entire meeting under one roof. This was arranged with the scientific exhibit on the main floor through the arena, the technical exhibit on the second floor, and the clinical lectures on the third floor, with the sections meeting in various auditoriums on the first, second, third, and fourth floors. Joining the Municipal Auditorium were the second building sections on preventive, and industrial medicine, and public health. Sections on gastroenterology, proctology, and radiology were held in the adjoining building. These meetings were well attended and the scientific and technical exhibits were very well attended. Under this arrangement the clinical lectures on Monday and Tuesday were attended, but because the House of Delegates met on Monday, Tuesday and Thursday, conflicts prevented attendance at some of the scientific sections.

The Section on Urology was attended by your delegate in the morning. This offered programs and papers that were in general excellent, both from the point of scientific interest and delivery, and followed by interesting discussions. The Sections on Pharmacology and Therapeutics were extremely instructive and interesting and were attended on one afternoon session by your delegate. The Section on Disease of Children seemed to your delegate to be one of the most excellent sessions I have attended at any medical association meeting. The splendid program in the Section of Nervous and Mental Diseases on Friday afternoon drew my attention, and I felt very well repaid for attending this session. Further discussion of some of the outstanding features of these sessions will be noted on the delegate's report to the State Medical Society meeting.

The excellence of the program for the scientific assembly well repays attendance at the meeting of the American Medical Association, but the outstanding feature to me was the realization of the splendid work being accomplished by the American Medical Association through its Council, its various committees, and its officers, not only in carrying on scientific medicine in general through the American Medical Association magazine, and its magazine Hygeia, but also the untiring effort and splendid work being accomplished for the welfare of the medical profession throughout the United States by this organization. I think one must attend the sessions of the House of Delegates to become aware of, and appreciate, what is being done by the American Medical Association for the physicians of the country, and that if *all physicians could realize* the *importance* of *this work*, we would have far better support of the component associations, namely, the State Society and the County Society, with a *full membership* of *all practicing* physicians, and all members of the medical profession, regardless of their status as teachers, research men, or practitioners of medicine. It is this plea that I would make to every person who has the honor of a degree of the Doctor of Medicine, that they should become an active member of their County Society and State Society, and help in carrying on the splendid work being done by these societies and the great parent society of them all—the American Medical Association.

W. E. BANNEN,
Delegate from Wisconsin.

DELEGATE TO AMERICAN MEDICAL ASSOCIATION

House of Delegates

The House of Delegates met in the Crystal Ballroom of the Hotel Benjamin Franklin at 10:00 A. M., Monday, June 8th. Sessions were also held Tuesday forenoon, Tuesday afternoon, and Thursday afternoon. The meetings were characterized by dignity of procedure, seriousness of purpose, and a remarkable unanimity among the delegates. Your delegates were present at all of the sessions and two of them were appointed by the Speaker to serve on Reference Committees.

At the opening session the House was addressed by the Speaker, Dr. F. C. Warnshuis of Michigan, the President of the American Medical Association, Dr. Wm. Gerry Morgan of Washington, D. C., the President-elect, Dr. E. Starr Judd, Rochester, Minnesota, and Dr. Geo. H. Simmons, Editor and General Manager Emeritus.

Resolutions of good wishes were ordered sent to Dr. Hobart Amory Hare of Philadelphia and Dr. John M. Dodson of Chicago, reported seriously ill, and to Dr. W. F. Ricker of Vermont, whose wife was reported seriously ill.

The Speaker also announced the death of Dr. E. Eliot Harris of New York, who represented his state in the House for fourteen years and was a former Speaker of the House of Delegates of the New York State Medical Society.

The President in his address advised that the Secretary and General Manager, the Editor of the Journal and the Director of the Bureau of Legal Medicine each be provided with competent assistants or understudies. This was approved by the reference committee on Reports of Officers and adopted by the House.

The President proposed that an honorarium be paid the President and President-elect instead of necessary expenses as at present. This proposal was not approved by the Reference Committee, and the Committee's report was adopted.

On the suggestion made by the President that the Association headquarters be removed to Washington, the Committee recommended that the matter be given more careful study and consideration and the detailed information given to the House at some later time. The Committee approved the establishment of a permanent office in Washington to facilitate the work of the Bureau of Legal Medicine. The Committee's report was adopted.

The suggestion that the teaching of Medical Ethics be given a place in the medical school curriculum was approved by the Committee and the report adopted by the House.

The further suggestion that hospital management should be largely under the control of the staff and that clinical programs in local, state, and national gatherings should be fostered by the Association was reported favorably by the Committee and adopted by the House.

Dr. Carl F. Moll, Michigan, presented a resolution asking that a commission on Qualifications for specialists composed of nine members be appointed by the Speaker of the House of Delegates with the advice of the President and Board of Trustees. The Reference Committee on Medical Education suggested that the resolution be referred to the Council on Medical Education and Hospitals for study and recommendations relative to the establishment of proper qualifications for those desiring to engage in special practice. The House adopted the Committee's report.

A resolution by Dr. H. H. Shoulders, Tennessee, recited the fact that the government had inaugurated the policy of rendering medical and hospital care to World War veterans with non-service connected disabilities involving the construction, staffing and maintenance of sufficient hospitals to care for all the veterans of the World War, thus bringing the government into unnecessary competition with civilian hospitals and providing a service which is bound to be of unequal service to the soldiers themselves.

The resolution petitions the Congress to abandon this policy and substitute therefor a Bureau of Disability in the Veterans' Bureau and to issue a disability insurance policy which shall provide for (a) the payment of a weekly cash benefit during a period of disability, and (b) the payment of hospital benefit sufficient to cover the hospital expenses of a veteran hospitalized for any disability.

It was resolved, that the proper officers of the Association be instructed to approach the officers of the American Legion and that each state medical association be requested to form a committee whose duty it shall be to approach the state and local Legion posts with a view to securing their cooperation in carrying out the proposed plan. This resolution was adopted by the House.

Dr. C. B. Wright of Minnesota presented a resolution protesting against the proposed removal of the Surgeon General's Library at Washington to the suburbs and suggesting that it be housed in a suitable fireproof building in the vicinity of the Congressional Library. The resolution was reported favorably by the Reference Committee and adopted by the House.

A resolution was presented by Dr. Roland Hammond of Rhode Island protesting against government limitation of the amount of medicinal liquor a doctor may prescribe for any one patient and against physicians being compelled to betray the confidences of their patients by keeping a record of their diseases and ailments for inspection of prohibition agents. Similar resolutions were presented by the New York delegation. Both resolutions were referred to the Board of Trustees for consideration through its regularly established Committee on the Medicinal Use of Liquor.

A resolution presented by the Michigan delegation providing that a charge of $2.00 shall be made to insurance companies for filling out preliminary

(Continued on page 688)

PRESS SERVICE OF STATE MEDICAL SOCIETY

No serum does so much for public health as printer's ink

PLANNING VACATIONS

Madison, Wis., July 1—Mothers taking their children on vacations must see that they drink three or four glasses of unflavored water every day, and no milk should be given to them which has not been boiled.

Joining with the Children's Bureau of Washington, the Educational Committee of the State Medical Society in a bulletin today declares that during the summer months the use of fresh vegetables and fruits will help keep children in good health.

"In planning vacations, be sure that the house to which you are going is clean and well screened and that the milk and water supplies are safe," declares the joint bulletin of the Medical Society and the Children's Bureau. "If traveling to a place where typhoid may be, have the children inoculated. Do not let the children drink water from roadside springs, or other sources not known to be safe. For short excursions, carry safe water with you. Boil all drinking water not known definitely to be safe.

"See that the child drinks three or four glasses of cool, unflavored water daily. Fresh-fruit orangeade and lemonade and tomato juice may be given also, but tea, coffee, and some bottled drinks contain a stimulant which children should not have.

"Use no raw milk. If pasteurized milk is unobtainable, boil the raw milk. For children under two years all milk must be boiled. Keep cold and well covered.

"Do not buy food for children from street carts or from counters where it has been exposed to dirt and dust and flies.

"Give the child plenty of fresh, green, leafy vegetables, and ripe, fresh fruits. Be sure that those to be eaten raw are washed in water known to be safe. Children over 18 months may have meat or fish and a fresh egg daily.

"Every child should be outdoors five to six hours daily, except on rainy or very windy days. In the hottest weather children should stay in the shade during the middle of the day.

"Children under six need a midday rest with at least one or two hours sleep.

"Let the child get well tanned gradually but not sunburned. Sun suit and sandals are all he needs for a large part of the day. In cooler summer weather he will need cotton underwear, a cotton suit or dress, short socks, shoes, and a sweater when he is not in the sun. Clothing that is too warm makes a child perspire too much and take cold easily."

* * *

PURE WATER

Madison, Wis., July 8—Picnickers should not trust to luck in selecting drinking water. While Wisconsin has made tests of hundreds of wells and water supplies which will be used by tourists during the summer, the Educational Committee of the State Medical Society in a bulletin today declares that the old adage that running water purifies itself is a fallacy.

"Wisconsin has brought the typhoid rate down by warning people to be careful about their water supply," declares the bulletin. "There need not be a single death in Wisconsin from typhoid if people would listen to this warning.

"Many persons have an idea that water from any running stream in the country is pure and fit to drink if clear and cold because 'running water purifies itself.' There is a grain of truth in that old saying, but like some other traditions, there is a pound of falsity there also.

"If a running brook crosses a farm yard or pasture or flows near a highway it is bound to pick up human or animal pollution, which, taken into the human system may cause disease. True it is that certain factors begin at once to render the water less dangerous but what change has it of becoming fit to drink? Let us see.

"First of all, solid material tends to settle out, the heavier particles first, but the amount of sedimentation depends on the rate of flow; the faster the stream the less settling. Thus solid material may be carried along distances from the place where the stream became polluted. Moreover, disease bacteria are so light in weight that there is comparatively little chance of their settling so long as the water remains in motion. If other streams join the first stream the pollution may become greatly diluted and then much less dangerous, but on the other hand, these tributaries may be highly contaminated and so increase the danger. Oxidation of impurities by air is rapid in fast flowing streams if the water flows over rocks or falls. Sunlight also has a greater chance to kill harmful bacteria if the stream is turbulent, so that fresh surfaces of water are constantly exposed. Disease germs tend to die off rapidly outside the human body.

"But all of the factors mentioned are frequently insufficient to purify water in a stream so that it is safe for drinking purposes. There is no way to tell by the appearance of water whether or not it is safe to drink. Not even an expert sanitary chemist can tell by a careful analysis.

"Why take a chance of a serious infection by drinking water of whose history you know nothing? Carry water from home along with you when you are taking to the road. If you are not going any great distance replenish your stock in some one of the larger communities where the water supply is under supervision. Don't drink from the roadside stream or spring."

* * *

SUMMER COMFORT

Madison, Wis., July 15—Seven hints on how to keep fit during summer months were announced by the Educational Committee of the State Medical Society today. The bulletin declares that with thousands of people now going on vacations, heat may be fatal, little scratches may lead to painful wounds, and flies may spread disease, but if the people observe seven simple rules their health will be greatly improved.

These rules are:

Let in the sunlight.

Sleep with the windows open.

Guard the water supply from impurities.

Dispose of sewage in the summer cottage by building a septic tank.

Protect food from decomposition and dangerous bacteria.

Remove garbage promptly from the home surroundings.

Abolish every breeding place for flies to prevent insect-borne ills.

(Continued on page 686)

THE JOURNAL BOOK SHELF

Textbook of Histology. For medical and dental students. By Eugene C. Piette, M. D., pathologist and director of the Laboratory of the West Suburban Hospital, Oak Park, Illinois. Consultant pathologist of the Chicago State Hospital, Chicago. With 277 illustrations, some in color. Price $4.50 net. F. A. Davis Company, Philadelphia, 1931.

The Physician of the Dance of Death. An historical study of the evolution of the dance of death mythus in art. By Aldred Scott Warthin, Ph. D., M. D., LL. D., professor of pathology and director of the Pathological Laboratories of the University of Michigan, Ann Arbor, 142 pages, 92 illustrations. Price $7.50. Paul B. Hoeber, Inc., New York, New York.

The Criminal, the Judge, and the Public. A Psychological Analysis. By Franz Alexander, M. D., and Hugo Staub. New York: The Macmillan Co. 1931. 238 pages. Translated from the German. Price $2.50.

Nutrition and Diet in Health and Disease. By James S. McLester, M. D., professor of medicine at the University of Alabama, Birmingham. Second edition, revised and reset. Octavo of 891 pages. Price cloth $8.50 net. W. B. Saunders Company, Philadelphia, and London, 1931.

Medical and Surgical Year-Book. Physicians Hospital of Plattsburgh. Comprising Wednesday afternoon invitation lectures; papers of the cardiac round table; the first Beaumont lecture; collected papers by the staff: 1930. The William H. Miner Foundation, Plattsburgh, N. Y.

The Diagnosis and Treatment of Brain Tumors. By Ernest Sachs, A. B., M. D., Professor of clinical neurological surgery, Washington University School of Medicine, St. Louis. 224 illustrations, including ten in colors. Price $10.00. C. V. Mosby Company, St. Louis, 1931.

Hemorrhoids, The Injection Treatment and Pruritus Ani. By Lawrence Goldbacher, M. D., Philadelphia. Illustrated with 31 half-tone and line engravings some in colors. Second revised edition. Price $3.50 net. F. A. Davis Company, Philadelphia, 1931.

Clinical Diagnosis by Laboratory Methods. By James Campbell Todd, Ph. B., M. D., late professor of clinical pathology, University of Colorado, School of Medicine; and Arthur Hawley Sanford, A. M., M. D., professor of clinical pathology, University of Minnesota (Mayo Foundation); head of section on clinical laboratories, Mayo Clinic. 7th edition, thoroughly revised. 765 pages with 347 illustrations, 29 in colors. Price cloth, $6.00 net. W. B. Saunders Co., Philadelphia, and London, 1931.

Practical X-Ray Treatment. By Arthur W. Erskine. Bruce Publishing Company. 1931. 116 pages, 28 illustrations and 12 charts. Price $3.50.

Chemistry for Nurses. By Harry C. Biddle, A. M. 322 pages. F. A. Davis Company, Philadelphia, 1931. $2.75.

Treatment of Injury by General Practitioner. By Clay Ray Murray, M. D., Ass't. Prof. of Surgery College of Physicians and Surgeons.

Practical Dietetics for Adults and Children in Health and Disease. By Sanford Blum, A. B., M. S., M. D. Head of department of pediatrics, and director of the research laboratory, San Francisco Polyclinic and Postgraduate school. Fourth edition revised and enlarged. Price $4.00 net. F. A. Davis Company, Philadelphia, 1931.

Diabetes. Its treatment by insulin and diet. A handbook for the patient. By Orlando H. Petty, A. M., M. D., F. A. C. P. Professor of diseases of metabolism, Graduate School of Medicine, University of Pennsylvania; physician in charge of departments of diseases of metabolism, Hospitals of the graduate school of medicine, University of Pennsylvania, and Philadelphia General Hospital; consultant in diseases of nutrition and metabolism, Shriners' Hospitals for Crippled Children, Philadelphia Unit. With illustrations and tables. Fifth revised and enlarged edition. Price $2.00 net. F. A. Davis Company, Philadelphia.

The International Medical Annual. A Year Book of Treatment and Practitioner's Index. Editors: Carey F. Coombs, M. D., F. R. C. P. and A. Rendle Short, M. D., B. S., 49th year. Price $6.00 net. William Wood & Co., New York, N. Y.

White House Conference, 1930. Addresses and abstracts of committee reports. White House Conference on Child Health and Protection called by President Hoover. The Century Co., New York. 1931.

Eye, Ear, Nose and Throat for Nurses. By Jay G. Roberts, Ph. G., M. D., F. A. C. S., Pomona, California. Licentiate, American Board Otolaryngology; chief of staff, Eye, Ear, Nose and Throat, Los Angeles County Health Center; member staff, Pomona Valley Community Hospital; Author of "Bacteriology and Pathology for Nurses." Illustrated with 102 half-tone and line engravings. Price $2.25 net. F. A. Davis Company, Philadelphia, 1931.

Heart Disease. Paul Dudley White, M. D. Instructor in Medicine, Harvard Medical School Physician, Massachusetts General Hospital, Boston. The Macmillan Company, New York, 1931, 931 pages, 119 illustrations.

The Infant Welfare Movement in the Eighteenth Century. By Ernest Caulfield with a foreword by George Frederick Still. Paul B. Hoeber, 1931. 203 pages, 8 illustrations. Price $2.00.

Food Allergy. Its Manifestations, diagnosis and treatment with a general discussion of bronchial asthma. By Albert H. Rowe, M. S., M. D. Lecturer in medicine in the University of California Medical School, San Francisco; chief of the clinic for allergic diseases of the Alameda County Health Center, Oakland; consultant in allergic and metabolic diseases, Highland Hospital; president of the Association for the Study of Allergy, 1927–1928. Price $5.00 net. Lea & Febiger, Philadelphia, 1931.

BOOKS RECEIVED FOR REVIEW

A Clinical Study of Addison's Disease. By Leonard G. Rowntree, M. D., and Albert M. Snell, M. D., division of medicine, The Mayo Clinic and The Mayo Foundation, Rochester, Minn. 12mo of 317 pages with 41 illustrations. Philadelphia and London: W. B. Saunders Company, 1931. Cloth, $4.00 net.

Proctoscopic Examination and the Treatment of Hemorrhoids and Anal Pruritus. By Louis A. Buie, B. A., M. D., F. A. C. S., section on proctology, The Mayo Clinic, Rochester, and associate professor

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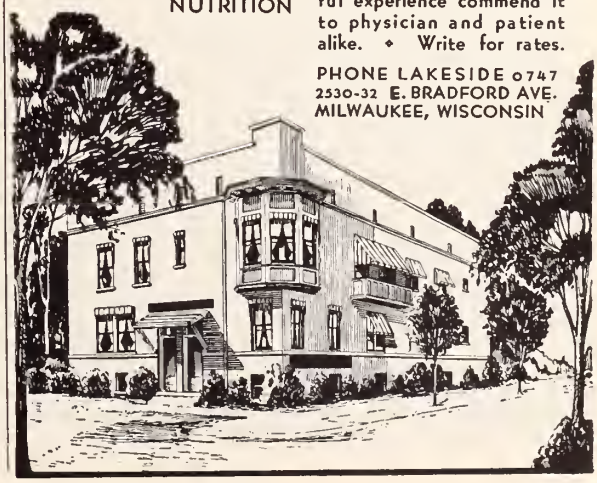

of surgery, The Mayo Foundation, University of Minnesota. Octavo of 178 pages with 72 illustrations. Philadelphia and London: W. B. Saunders Company, 1931. Cloth $3.50 net.

Collected Papers of The Mayo Clinic and The Mayo Foundation. Volume XXII. Edited by Mrs. Maud H. Mellish-Wilson, Richard M. Hewitt, B. A., M. A., M. D., and Mildred A. Felker, B. S. Octavo volume of 1125 pages with 234 illustrations. Philadelphia and London: W. B. Saunders Company, 1931. Cloth, $13.00 net.

Accidental Injuries. The medico-legal aspects of workmen's compensation and public liability. By Henry H. Kessler, A. B., M. D., F. A. C. S. Medical director, New Jersey Rehabilitation Clinic; formerly medical advisor, New Jersey workmen's compensation bureau; consulting orthopedic surgeon, Irvington General Hospital and Essex County Hospitals; chairman of the committee on Standard Practices in Compensation for Occupational Disease. Illustrated with 157 engravings. Price $10.00 net. Lea & Febiger, Philadelphia, 1931.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, 424 N. Charter Street, Madison, Wis.

The Doctor and His Investments. By Merryle S. Rukeyser, B. Lit., M. A., financial editor, Medical Economics and Dental Survey; financial and editorial writer, New York American and associated newspapers; associate in journalism, Columbia University; author, "Financial Advice to a Young Man," "The Common Sense of Money and Investments," and "Investment and Speculation." Price $2.50. P. Blakiston's Son & Co., Inc., 1012 Walnut St., Philadelphia, Pa.

There are few physicians who could not profit from owning this book and following its precepts. If its teachings were adopted the medical profession would cease to be a favorite on the sucker list of promotors of insecure securities. While systematic saving is by its means always easy it is far less difficult than wise investment of the savings. Most physicians need the advise of experts in selection of investments. It is, however, by no means easy to obtain expert advice based primarily upon the needs of the investor. The experienced advisors most readily available are bankers and dealers in securities who may be more interested in unloading securities than in the ultimate welfare of the investor. For this reason the physician should have a sufficient knowledge of the general field of finance and its procedures to be able to evaluate the advice of those whom he consults as to investments much as the wise layman learns enough about modern scientific medicine to be able to select with judgment a physician whose services are likely to be worth while. The author of the volume under review expresses his views in a clear and interesting way and is sufficiently specific to make his book of practical value. C. R. B.

An Introduction to Gynecology. By C. Jeff Miller, M. D., professor of gynecology, Tulane University School of Medicine; chief of the department of gynecology of Touro Infirmary; senior visiting surgeon, Charity Hospital, New Orleans. Illustrated. Price $5.00. C. V. Mosby Co., St. Louis, 1931.

This book of 327 pages including preface and index is planned as an outline of gynecology for third year medical students and the author is careful to point out that it is intended for no other purpose.

The book is divided into sixteen chapters corresponding to the sixteen class periods allotted to the introductory course. No therapeutic procedures are considered because the author believes that these should be taught in the fourth year. The subject matter is logically arranged and well developed. The chapter on endocrinology is presented with an unusual degree of clarity and includes the newer knowledge of the subject. The illustrations have been wisely chosen and clearly reproduced and the general make-up of the book is quite attractive.

While this book will in no wise supplant the larger text-books of gynecology, it does present the subject to beginners in a clear and concise manner. J. W. H.

Clinical Dietetics. A textbook for physicians, students, and dietitians. By Harry Gauss, M. S., M. D., F. A. C. P., instructor in medicine, University of Colorado, School of Medicine. Assisted by E. V. Gauss, B. A., formerly assistant dietitian, Presbyterian Hospital, Denver. Illustrated. Price $8.00. C. V. Mosby Co., St. Louis. 1931.

This volume will prove valuable to either a doctor or a dietitian. It is in many ways quite up to date. Perhaps an unnecessarily large amount of space has been given to a theoretical discussion but this is rather well done. The book is well made up and material is available.

This volume could have been improved by including a discussion of diets for women during pregnancy and lactation and by giving a more thorough presentation of the diet for normal children. There are, of course, still differences of opinion on such matters as the bland diet and the dietary treatment for gall bladder disease. Both of these diets appear rather unduly generous. It is also surprising to find the author stating that Vitamin E is the factor responsible for the prevention and relief of pernicious anemia. This is far from an accepted matter and it should therefore not be included as a fact. The book, however, has so much to recommend that it is to be classed as one of the best modern texts in clinical dietetics. E. L. S.

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MEDICAL LIBRARY SERVICE

There has been a rearrangement of the reading room of the Medical School Library during the last spring. The 340 unbound journals formerly in pamphlet boxes at the south end of the reading room have been moved to the north end of the room and fill one section of a separate standing stack and eight sections of a long wall stack extending across the north end of the room. They are alphabetically arranged according to title and to name of society or organization appearing in title. For instance, Journal of the American Medical Association appears under *American* Medical Association, Journal of. Bulletin of the Johns Hopkins Hospital is entered under *Johns Hopkins* Hospital, Bulletin of.

These journals are easily accessible, laid on their sides, the last dated number on top. These unbound journals cover at present chiefly the seven months of 1931, (January to June, inclusive), though certain journals for which there is a demand, (as the Lancet and the British Medical Journal) are still unbound for the last six months of 1930, and a few others which come out irregularly and infrequently are still unbound for 1929. Examples of the latter are the Biochemical Journal, and the Indian Journal of Medical Research.

The text books in the reading room now extend through nine double stacks comprising six sections each and are continued through two more stacks, labelled "10" and "11" in the basement. All the stacks from "1" to "11" are clearly labelled with subject and call number so that a reader can help himself. They are placed according to call number, the University Library classification, a modified form of the Cutter System.

A wooden stack on the east wall near the north end of the room, formerly containing federal documents and a miscellany, now holds "American Medical Association Pamphlets" on health, and "occasional journals".

Medical dictionaries, encyclopedia britannica, index medicus, and the index catalog of the Surgeon General's office are on the south wall replacing the unbound journals.

There are two locked, glassed cabinets of rare old gift books in the southwest corner of the reading room.

The federal documents are now in the basement stacks, Nos. "12", and "13". Principal among these are the weekly public health reports, U. S. naval medical bulletins and the U. S. veterans' bureau medical bulletins. Also in the basement are (1) the Robinson–Waite gift collection and (2) bound periodicals. A single stack No. "14" is set aside for duplicate books.

The Robinson–Waite gift collection, containing some old and first editions of medical books, a few dating to the 18th century, is on the east wall, south half. They are arranged according to call numbers.

The pamphlet collection which has now been organized and classified is on a stack facing the east windows in the basement. They are ordered according to call number and cover a range of subjects from "alcoholism" to "ventilation".

The bound journals, periodicals, and publications of institutes (such as Carnegie Institute, Leland Stanford University, etc.) are arranged alphabetically according to title in the same method of classification as the unbound journals on the reading room floor. The ends of each stack are labelled with an alphabetical list containing the full title of *each* journal contained in the stack.

There will be a typewritten list of all bound journals, their years and volumes as contained in the downstairs stacks, posted on the bulletin boards up and downstairs.

However, this is some of the evident progress at the time of writing, and our desire is to make the library month by month increasingly usable. We hope that during the state medical meeting that you will come in and inspect the library. J. B. P.

PRESS SERVICE

(Continued from page 681)

"Many conditions on the farm make health risks greater in summer than at other seasons," declares the Medical Society's bulletin. "Farmers will help to keep themselves on the safe side during the warm summer months by following carefully certain rules of hygiene and sanitation.

"The farmer needs a varied diet of wholesome food, limited in the main to three meals a day. He should drink liberally of water between meals. If possible, he should take 15 to 20 minutes rest after dinner and supper. Regularity in functions is absolutely necessary for health.

"Small cuts, bruises and scratches should be given attention to prevent infection or blood poisoning. In case of a puncture occurring, for example, by stepping on a nail, the wound should be opened and cleansed with boiled water. If it becomes inflamed a physician should be called at once. Advice should be sought in all cases of punctured wounds. Cuts and scratches should be treated with iodine or a wet dressing of a boric acid solution made by dissolving in hot water all the boric crystals or powder that the water will absorb. Care should be taken to keep dirt out of wounds.

"During very hot weather the farm worker needs periods of rest and should drink reasonable quantities of cold water—but not ice water. Upon the slightest sign of dizziness or unusual fatigue he should stop work for a little while and, if possible, bathe his head, hands and arms in cold water. Such precautions will tend to avoid sunstroke and injury from what may be regarded as heat exhaustion.

"The diet in hot weather should be largely milk, vegetables, fruit and cereals. It should contain very little meat. Constipation is at all times serious and likely to impair one's health, especially during the hot summer months. The general tendency is to eat too fast and too much. Remember that the teeth are a valuable part of the organs of digestion, and that a reasonable quantity of food is sufficient to keep up the strength and support activities, and at the same time to relieve the system of undue burden."

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A. M. A. DELEGATES

(Continued from page 680)

and final claim proofs was referred to the Bureau of Medical Economics for study and report to the next House of Delegates.

The committee on reapportionment recommended that the basis of representation shall be one delegate for each 800 members. On this basis, the membership of the House will be 173—the same as at present. California will gain one delegate and New York two, while Kansas, Maine, and Pennsylvania will each lose one delegate by this arrangement.

Dr. E. H. Carey of Dallas, Texas was unanimously elected President-elect; Dr. F. C. Warnshuis of Michigan was reelected Speaker of the House and New Orleans was selected as the meeting place for the 1932 session.

Signed,
J. GURNEY TAYLOR,
W. E. BANNEN,
JOSEPH F. SMITH,
Delegates.

A. M. A. DELEGATES

To the 1931 House of Delegates:

SCIENTIFIC EXHIBIT

This exhibit as planned, housed, and arranged was undoubtedly the most complete one ever offered to the members of the Association. The floor space occupied this year was 36,000 square feet and 183 exhibits were given as compared with 113 in Detroit and 101 in Portland. The statement was made that the aisle length was in the neighborhood of a mile and a half. It was an exhibit that was worth-while in every respect, as it presented so much material of vital interest to the physician. I believe that by the study of this portion of the meeting alone the members would be amply repaid for the time consumed.

It is almost impossible for one to give in detail the exhibits as presented, but I wish to emphasize the three special exhibits. At the request of the Committee on Scientific Exhibit of the Board of Trustees three special exhibits were authorized this year.

I. The Exhibit on Fresh Pathology. This was under the direction of Dr. Edward B. Krumbharr of Philadelphia, assisted by a committee of pathologists. Demonstrations were carried out during the entire session. There were four guest demonstrators who had stated hours each day and gave demonstrations in a room adjacent to the main hall. The following are those who gave demonstrations:—Dr. James P. Simonds, Chicago, Illinois, Pathology of the Gastrointestinal Tract and Liver, Dr. Milton C. Winternitz, New Haven, Conn., Pathology of the Lungs and Blood Vessels, Dr. Frank W. Hartman, Detroit, Mich., Pathology of the Kidney, Dr. Howard T. Karsner, Cleveland, Ohio, Pathology of Heart Disease. Each of these demonstrators gave two lectures of two hours each on the various days. They were very well attended, and the demonstrations were most excellent in every detail. The above named exhibit has become an annual feature.

II. Exhibit on Fractures. The exhibit on fractures was continued for the fifth year. It occupied seven booths and was under the direction of Drs. Nathaniel Allison, William Darrach, and Kellogg Speed, assisted by seventy-five physicians from all parts of the country and by members of the United States Navy. These demonstrations were given in separate booths with human models and ran from 9:00 A. M. until 5:00 P. M. continuously. The outline of demonstrations adapted for this meeting was:—1) plaster paris, 2) emergency treatment of fractures of the lower extremities, 3) compression fractures of the spine, 4) fractures of the radius—lower end, and 5) active movements and massage in treatment of fractures.

III. Exhibit on Varicose Veins. On account of the interest shown in this exhibit last year, it was decided to continue it at this meeting. It was in charge of Drs. Géza de Takáts, Chicago, Illinois, Claude F. Dixon, Rochester, Minn., and Howard M. Kern, Baltimore, Maryland. These demonstrations were conducted in the booths during the entire session, while special demonstrations were enacted in an adjacent room to the main hall at stated hours. Dr. Herman Beerman of the University of Pennsylvania demonstrated a special manikin which permitted the practice of intravenous injections. This demonstration again proved to be a distinct drawing card.

SECTION EXHIBITS

Nine of the sections of the Association sponsored group exhibits.

The Section on Dermatology and Syphilology had the largest number, sixteen in all, two of these being cooperative exhibits.

The Philadelphia Dermatological Society had an exhibit on Dermatophytosis which included material from eight contributors. The section exhibit on Erythema Multiforme included the work of sixteen contributors.

The Section on Pediatrics had eight exhibits in which the interesting subjects were:—(a) diet in pediatric practice, (b) relationship between underweight and malnutrition, and (c) selected exhibits of education and research character.

The Section on Laryngology, Otology and Rhinology showed eight exhibits, one of which received a Class II gold medal. This section also cooperated with the American Federation of Organizations for the Hard of Hearing in promoting an exhibit.

A new departure in the nature of an experiment was tried for the first time this year when a booth was arranged with a screen and projection apparatus so that members of the section could demonstrate motion pictures. A prearranged schedule was in force for this demonstration.

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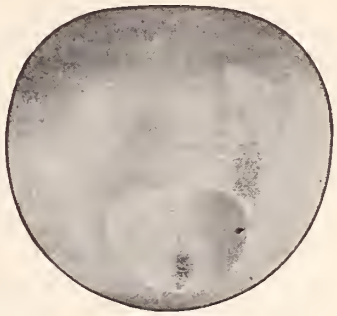

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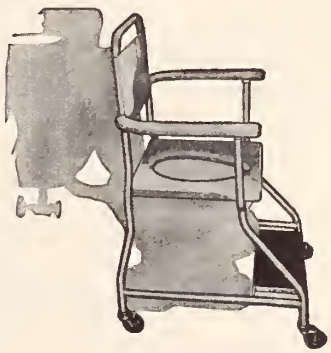

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Exhibit of Section on Nervous and Mental Diseases. This section sponsored nine exhibits, one of which received the Class II bronze medal.

Exhibit of Section on Obstetrics and Gynecology. This section promoted nine exhibits, which included bacteriology and pathology of vaginitis, laboratory diagnosis of early pregnancy, and endometrial implants.

Exhibit of Section on Ophthalmology. This section promoted ten exhibits on many varied topics, one of which received a Class II Certificate of Merit.

Exhibit of Section on Preventive and Industrial Medicine and Public Health. This section presented five exhibits which dealt in many details, including industrial hygiene. One of these exhibits received a Class II silver medal. This exhibit dealt with the effects of radium poisoning in the watch dial industry. This section exhibit included many excellent presentations from the Bureau of Mines, The U. S. Public Health Service, and the Bureau of Entomology and the Bureau of Animal Industry.

Exhibit of Section on Radiology. This section sponsored five exhibits. The material that was presented was of great interest, but the number of exhibits was less than in the past.

Exhibit of Section on Urology. This section showed five exhibits of a large variety of subjects which covered the urologic surgery in infants and children, surgical specimens, drawings of surgical procedures, and "before and after" photographs of urogenital tract disease and operations. Many specimens of pathological interest were presented.

Exhibits Educational in Character. These were classified and arranged under government and national organizations. The following were some of those participating:—American Association of Hospital Social Workers, American Association for the Study of Allergy, American Committee for the Control of Rheumatism, American Federation of Organizations for the Hard of Hearing, American Heart Association cooperating with the American Social Hygiene Association, American Hospital Association of Chicago, American Library Association of Chicago, American Pharmaceutical Association, Baltimore, American Society for Control of Cancer, Medical Society of the State of Pennsylvania, National Board of Medical Examiners, National Congress of Parents and Teachers, Pennsylvania State Department of Health, Philadelphia School of Occupational Therapy and the Pennsylvania Occupational Therapy Institution.

The American Medical Association had a very excellently planned series of booths which covered the Council on Pharmacy and Chemistry, Committee on Foods of the Council on Pharmacy and Chemistry, American Medical Association Chemical Laboratory, Bureau of Investigation, Council on Medical Education and Hospitals, Bureau of Health and Public Instruction, Bureau of Legal Medicine and Legislation, American Medical Association Library, Council on Physical Therapy, and Bureau of Exhibits.

This latter Bureau of Exhibits displayed the material available for scientific exhibits for medical meetings and popular exhibits for fairs, exhibitions and meetings of lay audiences.

Awards: The Committee on Awards reported as follows:

Class I

(Awards in Class I are made for exhibits of individual investigations, which are judged on the basis of originality and excellence of presentation.)

The gold medal to Jacob Furth, Henry Phipps Institute, University of Pennsylvania, Philadelphia, for original investigative work on experimental leukemia and excellence of presentation.

The silver medal to Bedford Shelmire, Baylor University of Medicine, Dallas, Texas, and W. E. Dove, U. S. Bureau of Entomology, Charleston, S. C., for original work on the spread of typhus fever by the tropical rat-mite and excellence of presentation.

The bronze medal to Eliot R. Clark, E. L. Clark, J. C. Sandison, R. G. Williams, H. T. Kirby-Smith, R. O. Rex, H. J. Hitschler, J. H. Smith and R. G. Abell, Department of Anatomy, University of Pennsylvania School of Medicine, Philadelphia, for original work on the growth of living tissue as seen in artificial chambers introduced into the rabbit's ear and excellence of presentation.

Certificates of Mermit, Class I, were awarded to the following (alphabetically arranged):

To Charles Armstrong, for exhibit illustrating the prevention of tetanus following vaccination against smallpox.

To J. G. Hopkins and R. W. Benham, for exhibit illustrating monilias and moniliasis.

To George Wagoner, J. C. Clark, John O. Bower and J. C. Burns, for exhibit illustrating work on the cause and prevention of deaths in spinal anesthesia.

To Edward L. Compere and Donald C. Keyes for the study of the nucleus pulposus.

In addition, the following exhibits are deemed worthy of special mention:

That of Eben J. Carey for experimental muscle pressure on bone. (This work has been recognized by awards at previous exhibits of the American Medical Association.)

That of I. S. Ravdin, C. G. Johnston, J. H. Austin and C. Riegel for investigation of the function of the gallbladder.

That of A. N. Richards and Arthur M. Walker for a demonstration of the now classic work of the direct study of the glomerular function in the frog's kidney.

Class II

(Awards in Class II are made for exhibits which do not exemplify purely experimental studies and which are judged on the basis of excellence of correlating facts and excellence of presentation.)

The gold medal to J. Parsons Schaeffer and Warren B. Davis, Jefferson Medical College, Philadelphia, for excellence of presentation of model specimens illustrating embryology, development and anatomy of the paranasal sinuses.

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed care Wisconsin Medical Journal.

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WANTED—Locum tenens work by capable physician from July 25th to September 1st and after September 15th. Licensed in Wisconsin; references furnished; will not compete. Address No. 843 in care of the Journal. JA

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The silver medal to Harrison S. Martland, A. V. St. George, Alexander O. Gettler and Ralph M. Muller, Medical Examiner's Office, Essex County, N. J., and Bellevue Hospital, New York, for excellence of presentation of exhibit illustrating the effects of radium poisoning in the watch dial industry.

The bronze medal to Walter Freeman and Karl H. Langenstrass, St. Elizabeth's Hospital, Washington, D. C., for excellence of presentation of specimens illustrating diseases of the brain with clinicopathologic correlation.

Certificates of Merit, Class II, were awarded to the following (alphabetically arranged):

To Vernon L. Hart for excellence of presentation of exhibit illustrating lesions of the joints in childhood.

To Parker Heath for excellence of presentation of exhibit illustrating the effects of disturbed lipoid metabolism as it affects the eye.

To William J. Hoffman for demonstration of method of obtaining biopsy specimens by use of a punch that coagulates the needle tract.

In addition, the following exhibits are deemed worthy of special mention:

That of Harry E. Mock, A. R. Morrow and Charles E. Shannon, illustrating skull fractures.

That of Eugene P. Pendergrass, Oscar V. Batson and Vincent C. Johnson, illustrating the temporal bone with clinical applications.

The following exhibits deserve special mention, but the work has been recognized by awards at previous exhibits of the American Medical Association:

That of Arthur J. Bedell on anomalies of the fundus.

That of Temple Fay, N. W. Winkelman, W. Edward Chamberlain and Frank W. Konzelman on cerebral atrophy.

That of Meredith F. Campbell on urologic surgery in infants and children.

That of Chevalier Jackson, Chevalier L. Jackson and Emily K. VanLoon, on diseases of the esophagus.

The Committee on Awards commends especially the group exhibit of the Mayo Clinic and Mayo Foundation as a model of presentation.

EDUCATIONAL CLASSIFICATION

A special Certificate of Merit is awarded to the American Heart Association and the American Social Hygiene Association for a cooperative exhibit on cardiovascular syphilis as the best exhibit in the educational (national organizations) classification.

The Committee on Awards commends the excellent demonstrations of the newer methods of diagnosis in pregnancy and of the complement fixation in gonococcus infection in women and also the exhibit on yeast vulvovaginitis.

The Committee on Awards extends to the Committee on Scientific Exhibit, to the Advisory Committee and to Dr. Thomas G. Hull, executive in charge, its most hearty congratulations on the superior material in this year's scientific exhibit, both from the standpoint of the exhibit itself and from that of the arrangements.

The special exhibits this year merit the highest commendation. These exhibits, namely, the exhibit on fresh pathologic anatomy, that on treatment of fractures and that on the treatment of varicose veins, would not have been possible without the active cooperation of experts from all parts of the country and of the staffs of the local hospitals and medical schools.

The committee also wishes to state that the cooperation of the nine sections in arranging special exhibits has been of great value.

* * *

Your delegate's report to you would not be complete without including the above report which epitomizes the outstanding exhibits.

Another word I should add is in relation to the impressiveness of the appearance of the entire scientific exhibit. The booths were not uniform in size, but were made of excellent material, uniform in color scheme, and were very excellently lighted so that one could readily study the exhibits with the least amount of effort.

I would further call the attention of this House of Delegates to the fact that permanent exhibits are kept at the American Medical Association headquarters, and I would urge the consideration of some of these exhibits for our state meetings. I believe they would be of distinct practical help to our members.

Respectfully submitted,

J. GURNEY TAYLOR,
Delegate.

The Art and Practice of Medical Writing*

By MORRIS FISHBEIN, M. D.
Editor, Journal of the American Medical Association, Chicago

This bulletin came in my mail today from Pittsburgh. It is issued by the Alleghany County Medical Society of Pittsburgh, and is edited under the rules and auspices of that society. It contains a little statement on the ideal case report. In the pamphlet are quotations from "The Art and Practice of Medical Writing" by editors Simmons and Fishbein.

The physicians in the Alleghany County Medical Society have offered twenty-five dollars for the first,

* Presented as one of a series of lectures offered under the joint auspices of the Medical Society of Milwaukee County and the Extension Division, University of Wisconsin, in Milwaukee, 1931.

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and fifteen dollars for the second prize to all interns in approved hospitals in Pittsburgh for a case report. These case reports are to be submitted to a special committee of the society and are to be submitted anonymously. They are to comprise one thousand words and will be rated as follows:

For general interest _____30 per cent
For completeness in essential details _____25 per cent
For absence of unnecessary matter _____15 per cent
For literary style _____20 per cent
For legibility of the copy_____10 per cent

All interns are requested to submit manuscripts and those manuscripts thought to be of sufficient value will be published in the State Medical Journal.

This is a serious effort to teach young men how to write and present case reports.

Many books are available on medical or scientific writing.

First, there is "The Art and Practice of Medical Writing" by Simmons and Fishbein. A new edition is now available.

Next, "The Writing of Medical Papers" by Mrs. Mellish, Editor for the Mayo Clinic. The book is succinct in presentation. The author has copied, and given credit wherever she copied, from practically all of the available books on the subject. A most valuable part of this book is the chapter entitled, "Don't". She expresses herself well. For example, she says: "Don't say, 'symptomatology' when you mean 'symptom'. Don't say, 'No pathology in the appendix'. Don't say, 'case' when you mean 'patient'. Don't confuse 'toxicity' with toxemia.' Don't confuse 'differentiate' with 'distinguish or contrast.' Don't overwork the word, 'hence.' Don't begin ninety-five per cent of your sentences with 'thus.'" I passed on a paper today in which the author used the word, "undoubtedly" about ten times. By the time I had finished reading it I began to doubt seriously whether he knew what he was writing about because he emphasized and repeated the word so often.

This is a general book on "The Preparation of Scientific and Technical Papers" written by Sam F. Trelease and Emma Yule and published by the Williams and Wilkins Company. It is a good book covering general science. It concerns all the standard forms of writing and provides much information.

This book is prepared by the Medical Research Council of Great Britain. It defines the form of papers to be sent through by people working under the Medical Research Council. They consider it important that a standard form be used in connection with reports of research. That book can be procured by writing to the publishers at 34 Queen Street, Westminster, England.

These other volumes are general books. Practically every good publisher issues a book for the authors who regularly contribute to his press. This is a book which the MacMillan Company provides. It contains information on writing, printing, style and punctuation.

The Editorial Board of the Wisconsin Medical Journal considers itself particularly fortunate to be able to present this lecture as the second of four to be published in consecutive months.

This is the style book of the "Detroit News." This book has a section on diction and likewise a section on spelling and punctuation. It also contains a nice article on the law of libel.

This is the style book of the "University of Chicago Press", one of the best presses in the country. It has various sections and footnotes on the hyphen, spelling and abbreviations, grammatical forms, indexes and all sorts of valuable information for authors. It also contains "Hints to Authors and Educators".

Finally there are several books on the subject of nomenclature. This is the "Belluevue Hospital Nomenclature."

There is also a book by Ponton which has been adopted by the American College of Surgeons.

Lastly there is the "International List of the Causes of Death" published by the Bureau of Census at Washington. That may be had by writing to the Government Printing Office at Washington. If all physicians were familiar with this list better vital statistics would be available.

ILLUSTRATIONS

Illustrations in medical papers include the halftone and the zinc, the charts and the tables.

The halftone illustration is usually made from a microphotograph, from a roentgenogram or from any picture which has a great deal of light and shadow. A microphotograph involves the most difficulty. In the first place, a unique microphotograph is difficult to get, that is, one that shows a picture which has not been reproduced already. Rarely can one find a form of tumor not previously illustrated by a microphotograph. One of the most difficult tasks that confronts an editor who receives a paper with microphotographs is the determination of which are necessary and which are unnecessary.

Certain forms represent research. Presume that one undertakes the study of a vitamin deficiency in dogs. Certain changes result in the bones. How many microphotographs should one show of the changes in bone? There would obviously be degeneration, hypoplasia, metaplasia, deficiency of growth, etc. In general, the microphotograph should be sent in only when it is necessary for the reader to see appearances which are being described.

In benzene poisoning there will be changes in the spleen, in the kidney and liver; these changes indicate the degree of the poisoning, cloudy swelling, or nephritis. It will not be necessary, in describing

OVER 50 WAYS TO KEEP A DIABETIC PATIENT HAPPY!

JELLIED VEGETABLE SALAD

(Six Servings)

	Grams	Prot.	Fat	Carb.	Cal.
1 tablespoon Knox Sparkling Gelatine	7	6			
¼ cup cold water					
1⅓ cups hot water					
1 teaspoonful whole mixed spices					
½ teaspoon salt					
⅓ cup vinegar					
½ cup chopped cabbage	50	1		3	
½ cup chopped celery	60	1		2	
¼ cup canned green peas	40	1		4	
¼ cup cooked beets cubed	40	1		3	
Total		10		12	88
One serving		2		2	15

Soak gelatine in cold water for five minutes. Bring to boil water, salt and spices. Pour on gelatine to dissolve it and add vinegar. Strain and set aside to cool. When jelly is nearly set, stir in the vegetables, pour into mold and chill until firm. Unmold on lettuce leaf or shredded lettuce and serve with mayonnaise or salad dressing. Garnish with sprig of parsley or strip of pimento.

CHOCOLATE PUDDING

(Six Servings)

	Grams	Prot.	Fat	Carb.	Cal.
1½ tablespoons Knox Sparkling Gelatine	10	9			
¼ cup cold water					
2 cups milk	480	14	19	24	
¾ cup boiling water					
1 square chocolate grated (1 oz.)	30	4	15	9	
Pinch salt					
Pinch cinnamon					
¼ teaspoon vanilla					
1 gr. saccharin					
Total	27	34	33	546	
One serving	4.5	6	5.5	91	

Soak gelatine in cold water five minutes. Melt chocolate in boiling water. Add gelatine and stir until dissolved. Add milk, salt, cinnamon, vanilla and saccharin. Stir well and chill. When nearly set, beat until frothy, mold and chill until firm. Serve plain or with thin cream or whipped cream.

ACCEPTED AMERICAN MEDICAL ASSN. Committee on Foods

THE Knox Sparkling Gelatine book of recipes for diabetic patients gives over 50 dish suggestions, two of which are shown above—but they are more than dishes conforming to a diet. They are dishes that help the physician keep the patient on the diet. Knox Gelatine combined with the wholesome foods permitted provides the bulk to satisfy a yearning stomach. The many *different* dishes give a variation that makes eating a pleasure from the standpoint of looks and taste.

Knox dishes give a patient latitude . . . not alone because of variation . . . but because Knox Gelatine is the plain gelatine without *sweetening,* flavoring or coloring. Therefore—it harmonizes perfectly with all the fruits, vegetables and other foods with which it is combined. A ready-prepared gelatin dessert mixture will have as high as 85% sugar—a fact which necessitates that physicians carefully prescribe KNOX Gelatine for dishes that will not violate the most rigid diet. Send for the book, using the coupon provided for your convenience.

KNOX *is the real* GELATINE

If you agree that recipes like the ones on this page will be helpful in your diabetic practice, write for our complete Diabetic Recipe Book—it contains dozens of valuable recommendations. We shall be glad to mail you as many copies as you desire. Knox Gelatine Laboratories, 443 Knox Ave., Johnstown, N. Y.

Name.....*Address*.....*City*.....*State*.....

these changes, to show by a microphotograph what the change was in each case. Such changes should be familiar to medical readers. In a rare blood disorder there may be an unusual change in the blood cells. It may be necessary to show these forms which actually differ from forms previously described. It is not satisfactory in such cases to submit pencil drawings or pen and ink drawings of the appearance. Actual photographs are better.

The next point of interest in relation to the microphotograph is the magnification. Under the microphotograph a legend should appear. When the microphotograph is sent to the printer's office, it is sent perhaps as a picture six by four inches in size, which will be much too large to be used as a picture for publication. Therefore it will be necessary for the printer to reduce the illustration. Instructions are sent to the engraver to reduce it one half.

The author sends in a picture. We prefer to pick out the part in the picture that shows to best advantage what is to be reproduced, and tell the printer to reproduce that much in the same size. If that is done the original magnification is maintained. If, however, we tell him to reduce it one-fourth, it is still a two thousand magnification, reduced one-fourth. The writer and the editor must see to it that the reader has a perfect understanding of what has been done. It may be a matter of great importance in the sizes of cells and bacteria. The reader must have, from the picture and your description under the picture, an exact knowledge of the condition seen and illustrated.

In dealing with roentgenograms, one is confronted again with the fact that invariably writers send in too many pictures.

The question most commonly asked is whether or not one should send to the periodical a plate, a print directly from the film or a reduction directly from the film. In the Journal of the American Medical Association press we prefer to have a print made from the film, the nearest possible to the size of the proposed reproduction. If a film is sent there is danger of its cracking in sending it through the mail. If it is rolled it is sure to crack, and there is a rule which states that we will not accept film submitted in the roll form. If it is sent flat, it should be put in corrugated paper and heavily wrapped.

Now the size of a column in the Journal of the American Medical Association is 3¼ inches and the size of two columns is 6½ inches. It is impossible to reproduce a roentgenogram 6½ inches wide; hence, in submitting to the Journal of the American Medical Association a reduction made from a film, the reduction being to the size of 3¼ inches wide, you need merely say to make the reduction to 3¼ inches wide, and the height will take care of itself.

The special journals published by the American Medical Association have a column width of four inches. "The Archives of Dermatology and Syphilology" has a four inch column width. If the print of the roentgenogram is submitted to those journals it should be 4 inches wide.

Each process costs money. An economical press, or one hard up, is likely to refer the author elsewhere or to ask the author for assistance.

A four inch column can be stretched to five inches by using part of the margin but it is preferable to have the picture correspond with the column width of the publication to which the article is sent.

The left and right are sometimes reversed when reproducing a roentgenogram. Unless the roentgenogram is marked "left" and "right" difficulties are bound to ensue in the reproduction process. For example, in a picture showing the heart there may be no difficulty provided the case is not one of situs transversus; but in dealing with the humerus or in dealing perhaps with the skull it is much more difficult to determine which is the left and which is right. Roentgenograms should be labeled as to positions. It is also desirable that microphotographs and roentgenograms be marked with white ink or an arrow inserted in the picture, pointing to the significant point.

The unnecessary roentgenograms will usually be combed out by the editor. For instance, should an editor receive twenty-eight roentgenograms, he is likely to return them. There are few publications which have room for twenty-eight or thirty pictures for one article. In studying these pictures the editor may do what I frequently do, send all twenty-eight back, saying to the author: "You have sent twenty-eight pictures. Only four are necessary to show what you are trying to show. Please pick out four of the twenty-eight." Then I may say, "If you are willing to bear the expense in using these extra pictures we will use them." If he has to pay the hundreds of dollars necessary he will hesitate in telling us to go ahead.

The halftone is made with a screen. If you will look carefully at it you will find that it has little dots on it, and if the dots are close together that portion will show dark. A two-hundred screen is extremely fine. Newspapers use somewhere between 50 and 100. The enameled stock required for half tones is more expensive than the machine finished or the newspaper stock. Newspaper stock takes a coarse screen. The zinc illustration reproduces well on any kind of paper. It is called zinc because it is made of a zinc amalgam. Zincs are most used in that part of the Journal of the American Medical Association devoted to new instruments and suggestions. All instruments that are illustrated, if worth while illustrating, should be drawn by a competent artist. Charts can also be reproduced by the zinc process. We have chart paper for sale which is ruled in black, with square of various sizes and which is supplied to authors at cost.

Presume that a chart is to be made showing the increase of the reticulocytes following the administration of liver extract, or noting the change in per cent of sugar in the blood. Let us suppose you are trying to show on the same chart the rate at which the fever fell and the decrease in the white blood count. Do not look around for the baby's

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new crayons. Colored ones are costly. Two colors are the limit for most colored illustrations and we proceed with four colors only when the author is exceedingly wealthy. The same effects can be realized by using a picture of lines in black and white: a line of dashes and a line of dots; a line of dashes and dots and a line of circles. One can get many variations in this way.

CHARTS

Charts have tremendous value. Quite frequently a case report consists of five lines and the chart tells the whole story. One of the most serious difficulties, however is the chart made on the wrong kind of chart paper. Some chart sheets are 5 x 7½, ruled with light blue ink. The blue ink will not produce the desired effect and green ink will fade out. When the chart is reproduced, it is mussy because lines are lost. This type of chart requires the halftone; it is therefore about five times as costly as the type of chart which can be made by the zinc process.

Next there is the physiologic tracing on smoked paper. It is made by having straws fastened to a kymograph on a wobbly table. It starts up and disappears. If the tracing is necessary, it is well to make a halftone. Such tracings are seldom reproduced without reduction. It would be difficult to make a reproduction that would fold properly. It would have to be folded about six times in order to fit in a magazine, and it would have to be hand-tipped in.

We have prepared labels to be placed on the reverse side of pictures. This is something we do not sell. If any author wishes to send in pictures, we send him labels. He can mark the size of the magnification thereon, supply his name and address, and other information.

The legend describing the picture should not be written on a half sheet of paper or on a small piece of paper. The glue has not apparently been invented that will hold the paper and the pictures together. The pictures come in with the labels off and have to be re-identified. The labels should not be pasted on the pictures because the man who makes the picture is not interested in the legend. The pictures go to an engraver, the legends to the compositor. The legends should always be written on a separate sheet of paper, written in the correct order, and the pictures numbered in their correct order so that the legend will be sure to correspond with the correct picture. The pictures should be sent flat and not rolled, and the pictures should not be grouped. I have about one author each Monday who wishes three pages of the Journal for the pictures to go with his article, and he will show how he wants it done. The editor does not like to cut up those wonderful groups but the editor must consider the problems of publication.

Finally if the author wants his pictures back after the article has been published he must so indicate in transmitting his manuscript.

Tables are another method of presenting data in concrete form. However, a table can be made a great waster of time and space. Some authors will develop tables that will take two office boys to roll them up and bring them in. Obviously it is impossible to handle a thing like that. The composing machine is used for such work and the man operating that machine is rather crowded for space. We usually photograph a table like that, and reproduce it as a zinc etching.

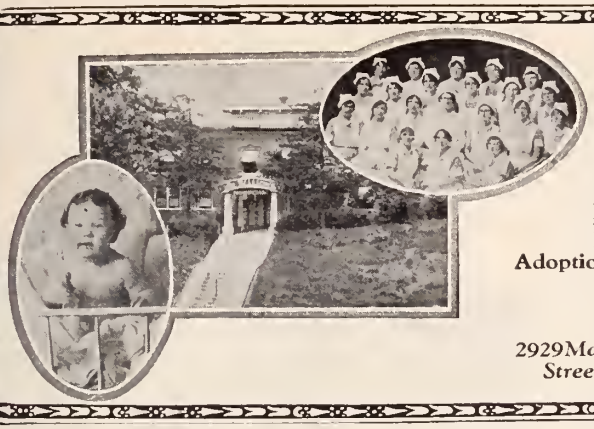
Here is a table, presumably for a consideration of the Wassermann test. It comprises a virtuous group. There will be forty-eight zeros, we will say with one one plus and one three plus. Eliminate the column and indicate by footnotes under the table these facts as they concern the two cases. Some authors will send in tables and on the right side is a column called "Remarks". This will usually be a wide column and include a complete case report. If printed the right side is solid and the rest will be left almost blank. The author must decide whether the material he is presenting actually lends itself to presentation in the form of a table. Unless it does, it is preferable to write the material out in the narrative form.

The table should be used only to present data that lend themselves readily to presentation in the form of abbreviations, or of figures. In such cases, all the columns should be vertical. The reading matter must all be horizontal. A table should not be put in by an author if it will necessitate turning the book all the way round in order to read. Few readers care for gymnastics with their reading. Tables may be more costly than halftones or other illustrations. Tables should not be included unless they are easily read and understood and shorten the work of the reader.

NEW OPTOMETRY DEFINITION

A new definition of optometry that will exclude the abuses of store sales by unqualified persons has been adopted by the Legislature and signed by the Governor. The new law is printed herewith, the new matter appearing in italicised type.

153.01 The practice of optometry is the employment of any means, other than the use of drugs, for the measurement of the powers of vision and the adaption of lenses, prisms and mechanical therapy for the aid thereof. No person shall practice optometry without a certificate of registration properly filed. This shall not apply to physicians and surgeons nor to the sale of spectacles * * * *containing simple lenses of a plus power only at an established place of business and as incidental to other business conducted therein without attempting to test the eyes and without advertising other than price marking on the spectacles. The term "simple lens" shall not include bifocals.* The furnishing, using or



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Clinical Facilities Medical and surgical clinics are conducted in Milwaukee County Hospital, and in a number of city hospitals, thereby affording adequate facilities for imparting bedside instruction under scientifically competent and experienced staffs.

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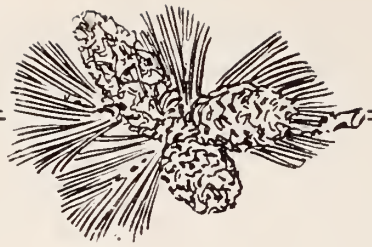

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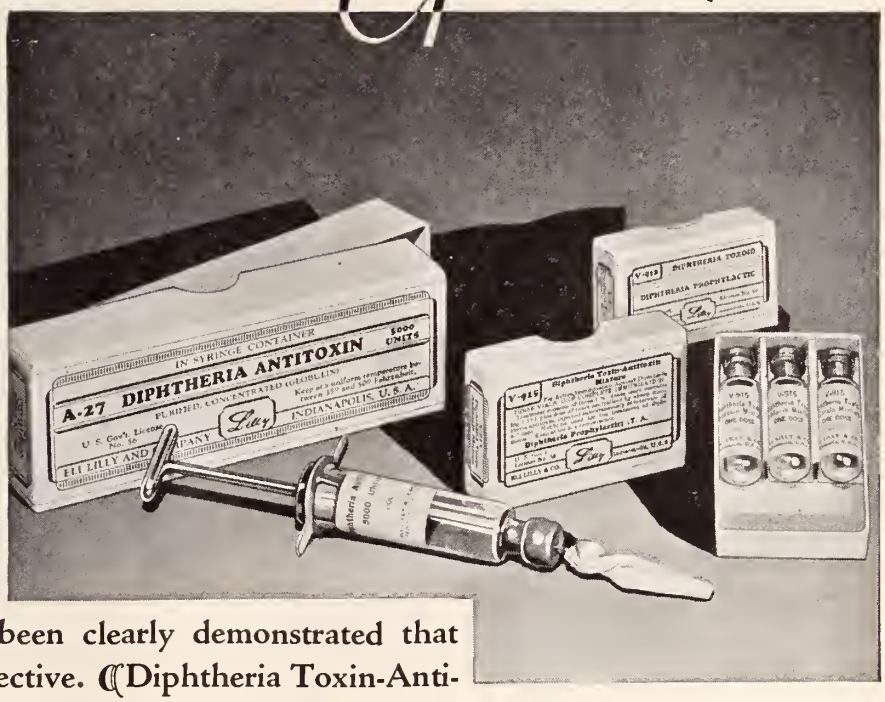

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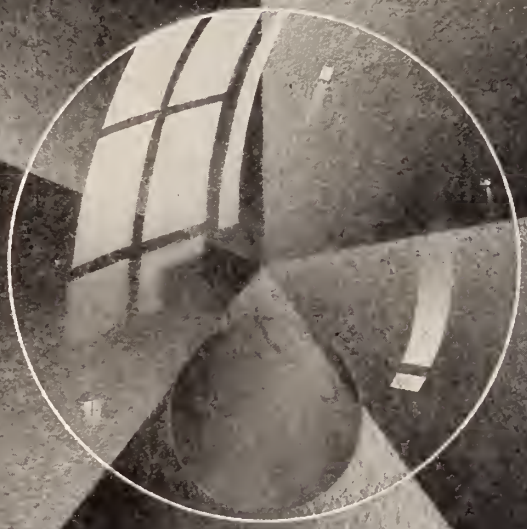

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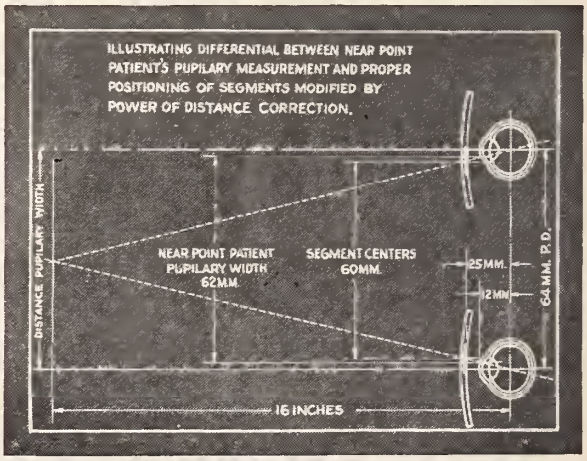

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The Wisconsin Medical Journal

Volume XXX SEPTEMBER, 1931 No. 9

The Immunization of the Pre-School Child Against Diphtheria by the Use of Toxoid*

By A. B. SCHWARTZ, M. D., and F. R. JANNEY, M. D.
Milwaukee

The prevention of diphtheria by immunization is long past the stage of experiment. Its usefulness has been proved by communities the world over. It has been so generally accepted by the profession that in the recent Conference on Child Health and Protection (1), a questionnaire revealed that out of one hundred general practitioners only one did not believe in having it done. Stimson (2) presents the evidence of its effectiveness in two communities where the educational program for immunization against diphtheria has been carried out. "In New York City where the Department of Health's educational campaign for immunization against diphtheria began in January, 1929, there were during the first eight months of 1930, 305 deaths, and 4,458 cases less than the average for the corresponding periods of the previous six years. In Yonkers, New York, where the campaign began in the autumn of 1927, the following figures tell the story":

	1927	1928	1929	1930 (Through Sept. 21)
Cases	438	152	66	20
Deaths	23	11	4	1

FitzGerald (3) compares the incidence of diphtheria in the vaccinated and unvaccinated. Among 5,000 unvaccinated children in the border cities of Canada, there were 40 cases of diphtheria, a frequency of one in 125. Among 15,000 who received toxoid, there were four cases of diphtheria, a frequency of one in 3,750.

That every child receive the necessary immunizing material is, of course, the most important part of the program so far as public health measures are concerned. But where the individual child is considered, none should nor can be pronounced immune to diphtheria unless, several months after receiving the diphtheria prophylaxis, a negative Schick test is obtained. A more general understanding of this requirement in the immunization program of the general practitioner would prevent the unfortunate and not infrequent occurrence of diphtheria among children who have had three injections for immunization but have not had a final Schick test. The assumption of immunity to diphtheria without the evidence afforded by a negative Schick test not only gives a false sense of security to the subject but as diphtheria may occur among those not completely immunized, the procedure itself is discredited in the profession and in the eyes of the public.

In the performance of large numbers of immunizations, it is, however, often difficult after the three injections have been given to have all the children return for a Schick test. Even in private practice, with a more ideal cooperation between patient and doctor, it is not easy to make the parent realize the importance of this final test.

It would appear, then, advantageous to utilize such materials in the prophylaxis as would insure the greater likelihood of a negative Schick test.

In a recent address Park (4) stated that after toxin-antitoxin, only 80 per cent will be fully immune. Reports from other communities place the number of immunes after three injections of toxin-antitoxin somewhat below this figure (10).

Ramon (5) and his co-workers have advocated the use of anatoxin (known as toxoid in this country), in preference to toxin-antitoxin, inasmuch as it is possible by its administration to secure a greater number of negative Schick tests, and in a shorter period of time. Various French and Canadian observers have obtained from 95 to 100 per cent

* From the Department of Pediatrics, Marquette University Medical School.

negative Schick tests by its use. In 1924, Zingher (6) also demonstrated the effectiveness of toxoid as an immunizing agent. Since then, several contributions (7, 8) have appeared in this country regarding its value as a prophylactic agent. Recently, Harrison (9) at the Hygienic Laboratory of the U. S. Public Health Service, reported a comparative study of the immunizing value of diphtheria toxin-antitoxin mixture and diphtheria toxoid. In 475 school children, diphtheria toxoid gave an immunity response of 95 per cent as compared with 64 per cent in 355 children receiving 0.1 L+ dose of toxin-antitoxin.

A year ago, the authors (10) reported the comparative results of the immunization of the pre-school child with toxoid and other agents. Following the administration of toxin-antitoxin in 361 children, 78 per cent showed a negative Schick test. Using toxoid in 128 children 98 per cent became immune. That study was made with material provided by the Connaught Laboratories, University of Toronto. Since then, toxoid purchased in the open market from a pharmaceutical house has been given to 317 children. On 200 of these children, a Schick test was done at periods varying from three months to one year after the last injection. Of these 200 children, 199 showed a negative Schick test.

It is interesting to note that the one positive Schick test was in a child whose maternal family had had an unfortunate diphtheria experience years ago. In 1898, the maternal brother, age seven years, developed diphtheria. No antitoxin was given any of the contacts. Three other children and the mother developed diphtheria. Two of the children died from it.

THE IDEAL AGE FOR IMMUNIZATION

The ages of the children in the present series were as follows:

6 mos. to 1 yr.	91
1 yr. to 2 yr.	138
2 yr. to 3 yr.	29
3 yr. to 4 yr.	26
4 yr. to 5 yr.	17
5 yr. to 6 yr.	10
6 yr. or over	6

Since the incidence and mortality rate of diphtheria is greatest from the second to the sixth year, it is particularly important to immunize the pre-school child. This age group is not reached by the public school health program. It, therefore, becomes largely the duty of the private physician to immunize children at this early age. As the natural immunity lasts only about six months in the majority of children, some time between six months and one year is the desirable time to immunize against diphtheria.

REACTIONS

In the group of children reported in this paper, the reactions constituted less than 5 per cent of those immunized. These reactions were rarely distressing. In only two instances did the family regard the reaction as of sufficient importance to request a house visit. The symptoms observed in these few reactors were local redness and swelling, anorexia, disturbed sleep and a slight rise of temperature.

In one child recorded in our original report, an allergic reaction occurred, shown by an immediate puffiness of the entire arm following the injection of the first dose of toxoid. This was an apparent sensitization to veal broth, which material is used in the preparation of toxoid. No allergic reactions were witnessed in any of the group reported in this paper.

The younger the child, the less likely does a reaction seem to occur. In the age group from six months to one year, reactions are extremely rare. Among those receiving toxoid were children with eczema, hay fever and asthma.

THE DESIRABILITY OF THE THREE DOSE METHOD

One argument offered against the use of toxoid is that the intervals between injections are three weeks instead of the one week interval of the toxin-antitoxin. This might increase the difficulty of obtaining the family cooperation in carrying out the program. Some workers have, therefore, attempted to shorten the procedure by giving two doses of toxoid. Ramon and his associates, as well as the Canadian observers, insist on the use of three doses to insure effectiveness. Report-

ed results indicate that giving only two doses of toxoid does not insure as large a number of negative Schick tests and, therefore, vitiates the most important advantage of toxoid as an immunizing material.

Ramon (11) quotes Fraser's comparison of the two injection method with the three injection method as follows:

Comparison of Number of Toxoid Injections on Reduction of Diphtheria Morbidity

No. of Children	Cases of Diphtheria	Cases of Diphtheria in same No. unvaccinated	% Reduction
2 injections—9,385	20	92	78
3 injections—17,209	14	169	92

Of 28 children who were given two doses of toxoid by the writers, 24 showed a negative Schick test, two positive and two doubtful. Interpreting the doubtful Schick tests as positives, gives four positive Schick tests out of 28; 86 per cent immunized.

THE DURATION OF IMMUNITY

Once immunity is acquired after the administration of either toxin-antitoxin or toxoid, a child usually remains immune. Parish and O'Kell (12) have expressed this by the dictum, "Once immune, always immune, if by immunity we mean a more ready protective response to the invasion of a specific toxin."

Regarding the relative duration of immunity following one type of material or another, FitzGerald (13) writes that it is his belief that the "duration of immunity following vaccination either with toxoid or toxin-antitoxin mixture is something that will vary with the individual and it is this variation in vaccinated individuals rather than a difference in the vaccinating agent which is significant."

Mozer (14) performed antitoxin titrations on 39 children who had been immunized with toxoid more than four years previously. Of these, only one showed less than 1/30 unit of antitoxin (the equivalent of a negative Schick test).

METHODS USED IN THE PRESENT STUDY

The toxoid used in this study was purchased in the open market from one pharmaceutical house. It was prepared according to the specifications of the United States Public Health Service. Three doses of 1 c.c. each were administered. The doses were given three weeks apart.

Most of the Schick tests were done with material obtained in the open market in New York City, and prepared by the New York City Health Department Laboratories. More recently, tests were done with material of pharmaceutical houses purchased locally. The efficiency of these materials was demonstrated by a controlled series of Schick tests done on children who had never received any prophylactic injections against diphtheria.

All injections and all Schick tests were done at the office. Vim Schick syringes were used in doing the Schick tests, and controls always used. Readings were done on the fifth day.

SUMMARY

After the use of three doses of toxoid as a diphtheria prophylactic, 199 out of 200 pre-school children gave a negative Schick test.

The reactions to toxoid in this age group were negligible.

CONCLUSIONS

1. Every infant should be immunized against diphtheria at about six months to one year of age.
2. The effectiveness of any diphtheria immunization program should be measured not alone by the number of children vaccinated against diphtheria, but by the number of negative Schick tests obtained after vaccination.
3. That agent is most effective in a diphtheria prevention program which secures the largest number of negative Schick tests.
4. The greatest advantage of toxoid as an immunizing agent is that it gives a greater percentage of negative Schick tests.
5. The reactions to toxoid in infancy are negligible.
6. Three doses of toxoid at proper intervals will, in the pre-school child, produce almost 100 per cent negative Schick tests.

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Endocervicitis and Erosions; Their Treatment by Electro-Surgical Methods*

By WILLIAM EDWIN GROUND, M. D.
Superior

I believe that the uterine cervix is a most important factor in pelvic pathology and most resistant to satisfactory treatment. This is conceded by gynecologists, and is confirmed by my own long years of experience. Located at the gateway between the infected vagina and the sterile endometrium, parametrium and peritoneum, it is in a constant state of turmoil for the major part of a woman's life. Through its lumen and its rich lymphatic supply must pass the materies morbi, the cause of most of the infectious conditions of the uterus, the tubes, the ovaries and the para-uterine structures. Not only that, but the cervix is the seat of 90% of all the uterine cancers. Like the teeth and tonsils the cervix may be the seat of focal infections.

The incidence of cervical infections is very large. Of some 6,000 women successively examined, Fulkerson found a little more than a third had cervical infections and that the condition existed in 78% of all cases between the ages of 20 and 40. Other authorities differ but little in their estimates of its frequency, and it is safe to say that, alone or in combination with other lesions, it is present in 70 to 85% of all patients examined.

The term endocervicitis cannot be strictly applied. The vast preponderance of all the infections of the pelvic cellular tissue and the tubes arise primarily in the cervix. Owing to the particular makeup of the metrial lining and its constant change through the menstrual function, the endometrium is not so easily affected. The essential lesion in endocervicitis is brought about by gonococcal or pyogenic organisms or both. As chronic infection of the cervix is a frequent legacy from childbearing, the ideal time for its recognition and treatment is during the post-natal period, before it has succeeded in producing the deepseated structural changes, the train of local symptoms and general ill health which characterize so many of our cases. One of the strongest arguments in favor of a post-natal examination of every

* Abstract of paper read at Annual Meeting of State Medical Society of Wisconsin, Milwaukee, September 11, 1930.

woman at the end of a month is the opportunity it gives for the detection of this lesion at an early and easily curable stage. For once induced the chronicity of the infection is proverbial and its removal far from simple, besides, the erosion is a pre-cancer lesion.

ELECTRO-CAUTERY

The essential thing to consider in the treatment of cervicitis is the infection in the racemose glands. These glands normally secrete mucous, but when infected secrete pus or mucopus. They are buried away in and under the mucosa. No vaginal douche can get at them. No topical application in sufficient potency can be made to penetrate the deep recesses of these ramifications. It remains then to destroy this germ infested lining of the cervix.

After everything is considered I am convinced that the application of heat is the most feasible agent at our command. Heat is the most potent sterilizer we have. The only difficulty has been the armamentaria necessary to its successful practical application. It is a difficult problem to destroy the infection without causing an inflammatory reaction and destruction of tissue, that will result in a reduction of the lumen of the cervical canal, sufficient to prevent drainage. Perhaps the most practical method of applying heat is by the use of the cautery. An ordinary nasal cautery with several tips of various sizes and a transformer can be gotten from any instrument house at a nominal cost. A large cautery such as a Post or Downs, is too clumsy for office use and the handle heats so much that the vaginal walls are liable to get burnt.

A thorough diagnosis of the exact pelvic condition must be made before treating the cervix by cautery, as a latent tubal infection may be lighted up.

A topical application of ten per cent cocaine solution is previously made to the cervical canal reaching well up to the internal os. The outstanding feature of my method of treating endocervicitis is to begin as near the uterine end as possible, for unless this is done a cure is not likely. Treating the erosions first results in a narrowing of the external os and a blocking up of the secretions from above. Besides it interferes with the treatment of the upper canal later, for unless the entire chain of deep seated racemose glands are destroyed a cessation of the leucorrhea will not be forthcoming. I leave the erosions until later. I find as the treatment of the upper endocervix proceeds the erosions have a tendency to disappear. We know the pseudoadenoma of Eden and Lockyer, popularly known as erosion, is merely the by-product of the higher up infection and when that is obliterated the eroded cervix, unless cystic, gradually improves.

A proper sized tipped electrode is selected and passed up to the internal os and the predetermined strength of current turned on. A slight sizzling is felt and often heard. The current is then turned off and the cautery tip moved down slightly or to a different point. The technic must be acquired by practice, going very carefully at first, aiming not to overdo the treatment. A few applications will usually clear up the average case. Then the attention may be turned to the eroded everted cervical lips. A few linear cauterizations radiating from the cervical opening will, within a few weeks, reduce a hypertrophied cervix to a semblance of normal. The cysts are readily punctured by the red hot cautery tip. The cautery point must always be introduced before the current is turned on.

The type of cautery just described is as old as the hills. It is heat generated in the terminal and conveyed to the tissues by convection. It is exemplified by the soldering iron, Paquelin's cautery and the electric cautery. The heat destructive effect is very superficial and fleeting.

The heat produced with the ordinary electro-cautery is not steady, and when buried in the tissues rapidly cools, so that a reliable tissue destruction and sterilization is not accomplished. Besides, the electrode gets hot and if an actual burn does not occur, the feeling of heat in the sensitive vulvo-vaginal parts is very perturbing to the patient.

ELECTRODESICCATION
ELECTROCOAGULATION
CUTTING CURRENT

During recent years the high frequency electric currents have been utilized for surgical purposes, and in many instances, to a de-

cided advantage. The heat is produced or generated in the tissues by the resistance of the tissues to the flow of electric energy. The concentrated electrode does not get hot, but the surrounding structures do. The term diathermy is used to designate this effect and means heating through. Diathermy is termed medical when the heat is maintained within physiological limits, and surgical when the heat is so concentrated at one point as to produce a devitalizing effect on the tissues.

Electrodesiccation is produced by the Oudin current and is monopolar. This simply means that the voltage is so high that the current flies off through the air, so to speak, into the patient's body which acts as a condenser and is emitted at the point of needle contact. In this case the point of the active terminal is not inserted into the tissue to be treated, but held an eighth of an inch or less away. This process is often known as fulguration, and is only used on the surface and not up in the canal. Its dehydrating effect is very superficial and is applicable to only the lighter erosions such as the "congenital" or those occurring in the nonparous uterus. Permit me to add that the ordinary very annoying and persistent urethral caruncle is most efficiently treated by this current.

Electrocoagulation means the entire destruction of the predetermined mass of tissue and is brought about by the use of the bipolar or d'Arsonval current. Its application requires two visible poles. One a larger or inactive pole is placed on any convenient exposed part of the body, and the smaller or active pole or terminal, is inserted into the lesion to be influenced. With a sufficient understanding of the nature and strength of the current used, the degree of coagulation can be regulated to a nicety. All this of course presupposes some experience. Electrocoagulation produces a complete cellular necrosis, with a variable inflammatory reaction in the adjacent tissues. The sterilizing effect of the heat extends much farther than the visible coagulation. There is also a zone around the coagulated area that is lethal to microorganisms and yet the heat is not sufficient to destroy normal tissue cells.

Electrocoagulation has no cutting action and is referred to as the damped or unsustained current. The cutting current disrupts the tissues by forming an arc between the needle terminal and the structures contacted, and moves freely with little coagulation. We have been using these agencies in all of our cancer work for several years and have experimented with practically every machine that has been put out for coagulating and cutting purposes, including the original radio knife or endotherm of Wyeth. We have used these currents in a wide variety of neoplasms, pre-cancerous conditions and cancer during the last seven or eight years. I mention this in this connection to indicate that it was no newly found fad that we had taken up.

Our experience with the methods described in the treatment of endocervicitis comprises upward of 300 cases. While this is not as large a number as some have reported, yet considering that they are mainly private cases with ample opportunity to follow up, we feel satisfied that the results are far ahead of any other line of treatment. We have practically quit doing Strumdorf and trachelorrhaphy, and what is more, 90 percent of our cases are office surgery. Practicing in a smaller city over a long time it is not difficult to keep track of our cases. We know what happens to them.

After many attempts I have constructed a very simple and efficient terminal for the endocervix. It is a long insulated handle with a flexible uterine end, tipped by a bulbous point. I use mostly 3 sizes, approximately $\frac{1}{16}$, $\frac{1}{8}$, $\frac{1}{4}$ of an inch. The tips screw off and on the terminal. The idea is to use a bulb tip to fit the interior of the cervix so as to contact all around. An ordinary uterine sound can be insulated with a small urethral catheter and made to serve the purpose in the average case. Even the urethral bougie can be requisitioned when a larger bulb tip is needed. The cord leading from the machine can be fastened to the active terminal by the appropriate form of clip. For the dispersing or inactive electrode I usually clip the other cord from the machine to the vaginal speculum. This simplifies matters

and obviates the necessity of placing a pad or plate on the skin of the patient.

Proceed by introducing a bivalve speculum. When the cervix is plainly in view it is cleansed, and powdered Vince is placed on a cotton wrapped probe and introduced up into the cervical canal. As this powder moistens it foams and thoroughly removes mucous and pus. The anesthetic solution is then applied. The active needle or bulb terminal is then inserted high up in the cervical canal and the current turned on until a sizzling noise is heard or felt. The current is then turned off and the electrode moved down slightly, when the process is repeated. This may be repeated two or three times, depending on the sensitiveness of the patient. If there is little reaction the procedure may be repeated in a week or ten days. After the whole of the endocervix has been gone over the patient is allowed to go for a month or six weeks. At this time it will be found that she has greatly improved. Go slowly at first. Err on the safe side if err you must, and most of us must. Practice on a piece of raw beef or liver, until a working familiarity with your machine setting has been obtained. A little more current or longer contact will be needed with the large tips, less with the small tips or the needle terminal. Visualize the converging lines of heat concentrating at the point of contact of active terminal, and contrast this with the comparatively static heat of ordinary cautery.

I have only attributed the benefits of high frequency to heat, but it is contended by many that the molecular changes brought about by the passage of the electric current adds to its therapeutic value.

When the endocervicitis is pretty well cleared up it is the time to cure the erosions. Often by this time however the erosions are much less and I have often noticed that this condition, unless the cervix was very hypertrophic and cystic, had all but disappeared. Puncture the cysts with the needle terminal and run a line of electrocoagulation radiating from the external os to the outer rim of the eroded area. Maybe two or three lines will be needed, particularly if there is much eversion. By knowing how and where to place the coagulation areas, the cervix, however badly deformed and eroded, can be moulded and shaped into a normal appearance. It is a great temptation to begin with the erosions. Do not do it for you will thereby narrow the outer cervical opening, prevent drainage and defeat the purpose in many instances.

As before stated most of this work is done in our office surgery. If the treatment has been rather heavy, the patient should be admonished to keep quiet and lie down most of the time, for a day or two, otherwise she will have considerable low abdominal pain and an aggravation of the backache. The vaginal discharge will be increased for a few days, and it will likely be tinged with blood. Rarely is it enough to alarm the patient, but occasionally there is considerable bleeding, so that it is well to inform her on this point.

Once in awhile a case may be so aggravated as to require hospitalization, or she is in a hurry to get through, or is too fussy to stand the repeated office treatments. This class of case is sent to the hospital and under anesthesia the entire endocervix is cored out by the cutting current, much after the style of the Strumdorf. There is surprisingly little bleeding. If there is a spurter it is touched by the coagulating current terminal, or the artery picked up by a hemostat and the current run down the forceps, thus sealing the vessel by coagulation. Oozing surfaces may be gone over by the bulb tipped coagulator.

The wound is packed with iodoform gauze and left for 3 or 4 days, and the surfaces allowed to granulate. If the manipulations are correctly done the result is almost perfect and there is little narrowing of the cervical canal. This I have verified in many cases where the operation has been done a year or more. Scar tissue formation is proverbially thin and elastic after electrocoagulation. If there should be evidence of cervical atresia it is readily overcome by gradual dilatation. Those who use the galvanic current are masters of the situation, for the introduction of a cervical electrode connected to the negative pole will soften up any cicatricial narrowing that may exist.

Electricity has a wide field of usefulness

in gynecology, and few there are that can practice this specialty successfully without the use of this agency in some form. Electrocoagulation is being utilized by many gynecologists, but there is no reason why the general practitioner that is electrically and gynecologically inclined, cannot use this very beneficent agency with equal readiness.

Cancerous and Pre-cancerous Lesions of the Skin*; Diagnosis and Management

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No matter whether a clinician is in general practice or doing a more limited work, sooner or later he encounters actual cancer or a condition suspected as being malignant. As cancer propaganda is being spread more and more among the laity, it seems timely to emphasize and reemphasize and again reemphasize the diagnostic and morphological criteria of cancerous and pre-cancerous conditions of the skin as well as attempt to evaluate our therapeutic agents. It is needless to speak of the dire necessity of making an absolute diagnosis in a suspected cancer as soon as possible.

PRE-CANCEROUS LESIONS

The two most common and most important pre-cancerous growths are senile keratoses on the skin and their histological homologues, leukoplakia in the mucous membranes of the mouth. Senile keratoses usually occur on the exposed parts of the body, especially the face. The lesions appear as sharply circumscribed, flat, elevated or warty, thick, scaling, brownish patches. Fewer women are affected than men, usually after middle age, and often associated with atrophic changes. These keratosic growths begin as small discrete brown or yellow spots. After a varying time many lesions become elevated and covered with adherent, rather firm, thick scales. Usually more than one lesion is present. The presence of an erythematous zone around the keratosis usually indicates a malignant change.

A senile keratosis is thus potentially a malignant lesion, and as stated by Eller and Anderson, usually gives rise to squamous-celled rather than basal-celled epithelioma. The majority of senile keratoses remain as such, often over a period of many years, without giving rise to true malignancy. However, they are definitely pre-cancerous and should be removed especially if there is any evidence of increase in size, an elevated border hardness of edge or surface, or easy bleeding under a crust (Stokes).

Senile Warts

Medical opinion is often sought as to the significance of so-called seborrheic keratoses (senile verrucae or warts) which appear especially on the trunk on people past middle age. Eller and Ryan have recently studied senile and seborrheic keratoses. Many text books fail to make any clear cut distinction between these two skin conditions. However, Eller and Ryan's work distinctly indicates that these are two distinct clinical entities, entirely different in their histologic structure and different in their predisposition to malignant change. These so-called senile or seborrheic warts are like drops of dirty candle-grease on the skin of the trunk of these older skins, and are usually not serious unless irritated, bleeding or growing rapidly.

Pigmented Moles

Besides beginning from senile keratoses, skin cancer can first occur in pigmented moles (some start, of course, from apparently normal skin). Pigmented moles are not necessarily present from birth; expert medical opinion differs as to which and what types are really premalignant. Although any mole may be the site of malignant

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change, usually only certain clinical types are apt to develop into melano-carcinomas. The bluish black or slate black mole is the dangerous type; it is usually non-hairy and may be slightly raised. As it is well known, when a cancer does develop, rapid metastases usually occur and the disseminated tumors while usually pigmented, may be non-pigmented. An unfortunate case was recently seen in a school teacher of 56 who had a pigmented mole appear on scalp some sixteen months ago, which was incompletely removed. Generalized metastases have just recently caused her death.

The general dermatological opinion is to leave these pigmented moles alone unless they are definitely located in areas subject to irritation or showing signs of growth. So the treatment requires considerable discretion and judgment as the prognosis is rather uncertain even with the most radical therapy. Microscopic studies by various investigators have shown that the size of the naevus on the surface of the skin may be misleading as to the actual extent in the tissues. Eller has seen several cases where the pigment-bearing cells were found inches away from the small papule on the surface, and were deep down in the fat following along the walls of the blood vessels and nerve fibers. While wide surgical removal by means of the high frequency knife has been used in the recent past, many dermatologists now feel that radium and x-ray are the best agents.

Leukoplakia

Leukoplakia of the mucous membrane of the buccal mucosa and the tongue is potentially dangerous, because it has so frequently been followed by cancer. In my opinion the possibility of exaggeration of the production of cancer in leukoplakic patches is not possible, for in my experience I have seen several young men in the early thirties pass away to an early death because of indifferent advice as to the importance and therapy of such areas.

Leukoplakia is a whitish thickening of the epithelium to the mucous membranes occurring as lactescent superficial patches of various shapes and sizes, which may coalesce to form diffuse sheets, (Andrews). The surface is generally glistening—at times it may be less so, being thick and silvery white. It commonly occurs on lips, especially on the commissures, interdental mucosa and on tongue and usually in men. As Stokes aptly states, "Look back toward syphilis; look ahead to cancer." In a series of cases I am now studying, about sixty per cent have had or do have syphilis and all have used tobacco. Of course, the use of tobacco must be stopped and all sources of irritation as ragged teeth, etc., removed. I have seen a number of luetic cases clear completely with specific treatment. Residual areas must be destroyed; electro-dessication and electro-coagulation are the methods of choice. Eller and Anderson mention the following therapeutic agents only to condemn them; radium, roentgen rays, carbon dioxide snow, chemical caustics of all kinds, and electrolysis. When leukoplakia becomes malignant, it develops into the squamous-celled type.

Other premalignant conditions are cutaneous horns, x-ray and radium dermatitis, arsenical keratoses, chronic fissures especially on the lips, scars due to syphilis, tuberculosis, lupus erythematosus and buris, and papillomas which are subject to irritation.

CANCER

Skin cancers are usually now divided into basal-celled epithelioma, squamous-celled and the basal-squamous celled types. The basal-celled epithelioma is very common around the face and neck. It arises, of course, from the basal cells. Quoting Stokes, epithelioma of both skin and mucous membrane is to be suspected (though not proved by any single point), (1) where lesions of an erosive or ulcerative character resist cleanliness, and bland applications (not styptics, cauterants and escharotics); (2) when lesions bleed on very slight trauma or contact; (3) when hardness can be felt either in margin or base; (4) when there is a raised rolled and pearly or nodular border or a cauliflower growth. Furthermore, we can add a fifth point in the squamous celled type—the ever present possibility of lymph node metastasis; the adjacent glands are enlarged, hard and non-inflammatory. A cancerous lesion may show signs of healing. I

will soon report several instructive cases that I have seen in a series of 122 clinical basal-celled epitheliomas.

Basal-Celled Epithelioma

When basal-celled epitheliomas ulcerate, the term rodent ulcer is often applied. Basal-celled epitheliomas do not metastasize but they do invade cartilage, bone, and large blood vessels and that, of course, is their serious complication; when there is periosted involvement, healing is very difficult. Some epitheliomas which by location and appearance are considered basal-celled, are really basal-squamous celled and metastasized. In this particular type, the importance of biopsy is readily seen; Hamilton Montgomery has recently collected a very interesting and instructive series of this type. Basal-celled epitheliomas practically never occur on the mucous membranes, although one has just been observed.

Squamous-Celled Epithelioma

The real serious type of epithelial cancer is then the squamous or prickle celled type; it is a neoplasm characterized by presence of adult squamous or prickle cells, occasionally in pearl formation. They occur usually on mucous membranes, mucocutaneous junctions, on extremities and occasionally on the face. Their course is often rapid, extension downward and into regional lymph nodes and into internal organs. Broders has very ably graded them according to their biological degree of malignancy.

The lip is a very common location for squamous-celled epithelioma. Prendergrass states that lip cancer is chiefly a disease of elderly men but is being recognized in an increasing number of younger men. Diagnosis before lymph gland involvement makes the prognosis much more favorable; when the lymph nodes are involved, these become a combined surgical and x-ray proposition rather than straight dermatological.

As Andrews says, "Generalization about both locations are both helpful and misleading. Both basal and squamous-celled type of lesions may occur on the skin. However, the basal-cell lesions are formed chiefly on the face, especially on the nose, forehead, eyelids, temples and upper lip, whereas the squamous-cell growths are found principally on the mucous membranes, at the mucocutaneous junctions, and on the extremities."

The crux to the whole situation is, of course, early diagnosis. Both Weidman and Ewing feel that the removal of a small carefully selected portion of a readily accessible tumor seldom results in any harm. Eller and Montgomery believe that the danger of a biopsy are overestimated.

Histopathology

The pathology is usually quite convincing as to type and degree of malignancy. Pseudo-epitheliomatous changes, however, must be kept in mind. While associated part time with Dr. F. D. Weidman for some three years in some histopathological and mycological research at the Laboratory of Dermatological Research of the U. of Pennsylvania several years ago, we encountered some nine cases where histology of ulcers showed epitheliomas but clinically not so. All healed under expectant treatment. Since that time I have seen one striking example of this possibility—proper interpretation of a histological section saved a leg from being amputated from a girl of thirteen. I felt that the clinical diagnosis in this girl was a traumatic ulcer; it healed completely under protective soothing preparations.

In regard to biopsies from malignant or suspicious malignancies, I am taking sections from practically every case. The new radio loop is a great help in taking a biopsy.

Treatment of Epithelioma

Stokes tersely sums up the therapy, viz.: "Use (1) cautery or cautery knife; (2) electro-dessication or coagulation; (3) total excision plus above; (4) x-ray and radium only for experts. Do not use (1) silver nitrate; (2) caustics; (3) iodine; (4) CO_2 snow; (5) curette without cautery; (6) small doses of x-ray or radium."

In a nut shell, Eller makes a very important notation as to treatment. He says: "The best results are obtained by those who follow no routine or who do not become faddists of some one physical agent; one should individualize in each case and be prepared

to use the various forms of therapy as may be indicated."

While some experts like McKee have attained excellent results entirely with roentgen rays; others, like Quick, have reported equally good results with radium; and Pfahler, with both. My own experience, similar to Eller and Fox, has been preliminary destruction by electro-thermic methods, which has increased the number of cures and decreased the amount of radiation necessary although the latter was used in conjunction. About one quarter of an inch of normal skin was included to prevent recurrence. After a personal experience with a number of re-occurring cases which had occurred from radium and x-ray in other hands, I believe the preliminary electrothermic destruction to be almost a necessity to produce the highest percentage of cures. Two cases out of 122 basal-celled epitheliomas that I have encountered recurred with this treatment; one was cured by further treatment and the other turned out to be a basal-squamous celled type with lymph node metastases. Hamilton Montgomery recommends wide surgical excision for the latter type; this was done recently with the assistance of a surgeon and the results remain to be seen.

Squamous-celled epitheliomas present a more difficult problem than the basal-cell type. As stated, they usually grow more rapidly, may metastasize early and often are more resistant to radiotherapy. Wide destruction of the involved area with electrocoagulation followed by radium or x-ray is the treatment of choice. Radon seed implants has been an excellent aid in several lip cases that I have recently had. A most instructive case was just observed where a beginning squamous-celled epitheliomas with ulceration occurred on the lip of a young man of 32. My discussion of treatment is of course limited to localized lesions without apparent glandular involvement. Prophylactic x-ray treatment of the draining lymphatics is urged.

Paget's Disease of the Breast

Discussion of cancer of the skin is not complete without a brief mention of this entity. It is now generally agreed that Paget's disease of the nipple is a definite carcinoma of the intra-epidermal portion of the mammary duct where it may remain stationary for a long period. Consequently surgical removal of the breast followed by irradiation is indicated. A woman of 45 recently seen in the dermatology clinic of the Northwestern University Medical School refused to have a breast amputation; a superficial response, at least, to radium is already noted.

Paget's disease is a unilateral mild eczematoid condition, which may spread over the areola and become spread over the nipple and become ulcerated or eroded. Pautrier has just recently showed rather convincingly that Paget's disease of the nipple is always associated with glandular carcinoma of the upper parts of the mild ducts. A palpable tumor may not be felt but is cancer just the same.

104 South Michigan Avenue.

The Traveling Venereal*

By SIDNEY J. SILBAR, M. D.
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The traveling venereal has long been a problem for both the general practitioner and urologist. By this title is meant one who must leave his doctor (let us call him the base physician), and through circumstances over which he has no choice, leave to travel. The difficulty, simply stated, is that of being unable to control the patient from a (1), psychological, (2), hygienic, (3), dietetic and (4), medical viewpoints, once he leaves the immediate attention of his base physician.

When the average patient becomes infected per venerea, he sooner or later seeks medical aid. His complete rehabilitation is dependent solely upon his cooperation with his medical advisor, and by the maintenance of an explicit, celibate regime, with which he has been instructed. Any digression from such a standard is deleterious to himself, both

* Presented before Wisconsin Urological Society, Madison, Nov., 1930.

from the standpoint of the weakening of his morale, and as a hindrance to his physical progress. The writer believes the former more important that the latter, for by such digressions, be they mental, physical, or sexual, the bulwark of discipline which is so important in the treatment of a specific urethritis is undermined.

The control of a venereal patient from the psychological viewpoint is difficult under the best circumstances.

PSYCHOLOGICAL VIEWPOINT

In the treatment of all ailments, whether they be organic or functional, the relationship of a patient to his medical advisor must be one of absolute confidence. The maintenance of that confidence is dependent upon the physician's understanding of his patient's mental attitude toward himself, the physician, and to the disease. Anything which will disrupt this psychological balance will in turn disarm that confidence.

Let us take the model patient and see what occurs when he travels. He leaves his base physician; he is instructed to see another in another town. Like the proverbial Chinese traveler, he finds himself in another land, different customs, different language, different politics. He has had the greatest confidence in his original physician, listened to all his teachings, accepted his etiology, pathology, prognosis and treatment without a thought. Now all is changed, all that was proper before is improper. All that was right is wrong. How often have we heard this when stating a truth, changing a medication or some form of treatment. "Doctor, so and so in such and such a city said this thing you are going to do to me is absolutely wrong and he said this and this should be done." He leaves the confines of the second physician, and again the same thing occurs, and so on, until all the precepts that were originally correct are now incorrect with the result that the patient finds himself mentally perturbed, which, added to his already morbid attitude toward life, is certainly nonconducive to the favorable outcome, when one of the fundamental rules in the treatment of gonorrhea is mental rest.

HYGIENIC VIEWPOINT

The second most disturbing factor is that of physical rest. This should and must be paramount, heading all of our known rules for hygiene. It is best to emphasize this at all times. One away from one's bed does not rest well even though he be a hardened traveler, Pelouze maintains. The incidence of complications is far greater in the traveler than in the resident patient. Another element to be considered by this type of patient is the factor of an already disturbed and weakened morale. A man alone in a strange city is desirous of companionship. His loneliness hinders his exercising selectiveness. The result may be sex digressions.

In the experience of the writer it is not uncommon to find, where one infection existed when the patient left, more than one new type, plus complications of the first, were present upon his return. This occurred but recently. A patient left to travel through Wisconsin, Michigan and Minnesota with full instructions as to how he was to conduct himself and with a list of physicians to call on for treatment. Upon his leaving he had an acute gonorrheal infection, which was under control. Upon his return six weeks later, the following infections and complications could be enumerated: a fulminating gonorrhea, posterior prostatitis, seminal vesiculitis, primary sore, balanoposthitis and inguinal adenitis. His only answer was that he had been lonesome.

DIETETIC VIEWPOINT

The next difficulty to be met with is that of the diet. This in itself is the most easily controlled of the four. Most male patients respond, peculiar though it may seem, to a strict dietetic regime. This may be difficult on the road, but in the writer's experience the patient will go without certain foods to the point of going hungry, rather than partake of that which is forbidden. On the other hand, this factor must be stressed as of great importance because by dietary laxity other digressions may follow.

MEDICAL VIEWPOINT

The last and most important consideration, is that from the medical viewpoint. In this,

the patient is at no time to be blamed. We, of the medical profession, must assume the entire responsibility. Briefly stated, the variance in treatment undermines the confidence of the patient for his physician and for medicine in general. The following incident is a case in point. A patient left the office with a suggestion of detailed method of treatment, simple, and of such a nature that any backwoods practitioner could follow it without the least difficulty. Namely, first to void, then fill the bladder with 1-10,000 permanganate, either with bulb syringe or gravity method, then a massage and lastly to void. The patient, an ex-druggist, was instructed to keep notes on what treatment was given. To the writer's great amazement and surprise, of seven physicians seen but one carried out the above suggestions. The others, in turn, interpolated neo-silvol, argyrol, a white colorless solution, perhaps some compound of zinc sulphate, protargol, urethral suppositories and the last filled the bladder with a catheter and then attempted a passage of a sound, size unknown. Each physician maintained that his treatment was the correct one, and that which was suggested was incorrect. The majority took no history, and all but one were seeing the patient for the first time. Is it surprising then that complications in the traveler who wishes to cooperate are far greater than that of the resident patient?

The writer has experienced "self treatment" to be accompanied by one complication following another. On the other hand, when the patient uses self treatment he can hold no one at fault should this occur. The question then resolves itself into a very pessimistic outlook for the traveler, once he leaves his base physician. Will he do less damage to himself by going the rounds of disinterested physicians, or by self treatment?

The purpose of this paper can readily be seen. It is to call attention, not so much to the fact that every doctor has his own type of treatment for specific urethritis and disregards all others, but rather to call attention to the inability of the profession to cooperate with a base physician who really knows, understands and has the welfare of his, the traveling patient, at heart. No doubt this is true of medicine in general, but so much irreparable damage can be done in the treatment of a case of specific urethritis that this point has been stressed most emphatically. The writer does not, however, wish to convey the thought, that his type of treatment is the *only* one, in this day of uncertain methods.

CONCLUSION

1. The confidence of the patient must at all costs be maintained. Changing doctors leaves the patient with a morbid mind which is non-conducive to cure.

2. Hygiene must be emphasized. There are more complications in the traveling venereal than in the resident.

3. The diet is of importance as a disciplinary measure outside of the hindrance to the medical progress.

4. Medical treatment, other than that which is ordered for the patient by the base physician, is usually deleterious to the patient.

Medical Social Work For Sanatoria*

By METTA BEAN
Director Social Service Department, W. A. T. A.
Milwaukee

From the very beginning of the anti-tuberculosis movement, steady and marked achievement has been made in the technique of case finding and diagnosis and in the care and treatment provided by sanatoria, hospitals and preventoria. Probably the sanatorium idea is the biggest single advance that has been made in fighting this disease.

In Wisconsin we have an investment of approximately $6,000,000 in institutions for the care of the tuberculous, requiring a yearly budget for maintenance of approximately $2,000,000. Let us examine for a

* Read at the Wisconsin Mid-Year Sanatorium Conference at Lakeview Sanatorium, Madison, Wis., June 20, 1931.

moment, if you please, the dividends on our investment. The Wisconsin Anti-Tuberculosis Association has recently made studies of a group of Wisconsin sanatoria, which reveal some deficiencies in our program. And startling they are too, when one considers the splendid physical set-up of our sanatoria and the high standard of their medical and nursing service. These studies point out three things on each of which I ask your careful consideration because it is largely on these three points that I shall hang the burden of this paper.

First—from 60 to 90%, averaging at least 75%, of patients in Wisconsin sanatoria are being admitted in an advanced stage of the disease.

Second—30 to 60% of discharged patients leave against advice. When it is remembered that another 20 to 40% of the discharges are by death, it will be seen that only one-third to one-half of all patients, or even less, remain in our sanatoria long enough to get the full benefit of sanatorium care.

Third—one-third to one-half of those who leave with medical advice, reactivate within five years after their discharge.

Now if only a small fraction of our patients leave the sanatoria as arrested cases, as these figures indicate, the question arises: Are we maintaining our institutions in main only for isolation purposes? And are we getting the results that our investment warrants? If we are to get the maximum benefit of our investment, three things, it would seem to me, must be learned. How to get our patients earlier, how to keep them in the sanatorium longer and how to keep them well after they have resumed their place in society. It is obvious, of course, that the solution of these problems involves in a very high degree both good medical service and good nursing service. But these matters are not alone medical problems nor nursing problems. To a great extent, they are problems of human adjustment, involving the psychology of the patient and his family, his environment, family relationships, educational background and employment. And just as sanatorium medical problems need trained and experienced medical intelligence for their solution, and sanatorium nursing problems trained and experienced nursing intelligence, so do these problems of human adjustment need for their solution the scientific handling of people trained and experienced in matters of human adjustment—in other words, sanatorium social workers.

It has been one of the functions of the social service department of the W. A. T. A. to serve as a clearing house for problem tuberculosis cases with the idea of not only meeting the emergency needs in each instance, but of working out a satisfactory solution of the larger problems which they present. Planning for the future in every case where tuberculosis is present requires long term planning.

To date, about 650 of such cases have been referred to us by doctors, employers, teachers, nurses and church or club groups. Among these 650 cases in our files, there are only a few that have not had, or are not having, or do not need sanatorium care. Militating against their co-operation in the matter of satisfactory cure-taking, loom social problems that are not the sanatorium superintendent's job, nor the doctor's nor nurse's. Then whose job are they and what are we doing to supply the special service to meet this need? What are other parts of the country doing in this direction?

Here, perhaps, is the answer: the American Sanatorium Association has recently gone on record as endorsing social service departments for all sanatoria.

ADVANTAGES OF SOCIAL SERVICE

I want to summarize here, briefly, the three services that sanatoria would profit by if they added medical social work to their services. By medical social work I mean social case work as it becomes applied to sick people. If successful recoveries are made, social study and treatment must be interwoven with the medical treatment. Thus the social worker interprets the doctor's recommendation to the patient and his family, and interprets the latter's psychology and social history to the doctor, so that both the doctor and the social worker become an ally each to

the other with the patient's welfare as their mutual objective.

The first service of the social worker to the sanatorium is that of discovering earlier cases for admission. This includes case finding, persuading contacts to be examined at offices of private physicians or at clinics, and guiding the patient in making a financial adjustment for a long period of institutional care. The County Judge could rely upon her for investigation of cases asking county care and thereby provide a connecting link between the court and the sanatorium. In cases where the financial status of the family changes during the patient's period of treatment at the sanatorium, this fact would be known to the social worker through her contacts with the family and her knowledge of their resources, and the court could modify its decision whenever conditions make a change expedient or desirable.

The next phase of the social worker's job, keeping the patient at the sanatorium, is that of patient management or the adjustment of the patient to sanatorium routine. It seems to me that this is the outstanding problem among those confronting social workers specializing in tuberculosis. Keeping the patient in the sanatorium is a job that requires a knowledge of the psychology of the patient and the members of his family and the reasons back of this psychology. The social worker interprets the welfare of these individuals to each other and plans ways and means for their better appreciation of the value of continuous sanatorium care. She adjusts vexing situations in the home that worry the patient and are all too frequently the cause of his leaving against advice. Back of the ambiguous term "homesickness" which we hear used perhaps more than any other as the reason for leaving, are little annoyances that disturb the mind and which, when carefully analyzed, can generally be ironed out to the satisfaction of both the patient and his family, but it may take a lot of time and patient, skillful work.

Our third question—how to keep patients well after they have been discharged from the sanatorium brings us to the third service rendered by the social worker—that is, follow-up or after-care. This, like the first two, involves the skill of a trained person experienced in social work and familiar with the recommendations of the doctor and the patient's potential employment capacity, his educational background, family relationships, work history and mental attitudes. This subject has already been discussed by one who is doing intensive work in this field.

There is one more service supplementary to the other three that belongs to the sanatorium social worker by virtue of her required training. This is community organization and co-operation with the health and social agencies and lay organizations in the county. Many hospitals are using their social service departments as their liaison representatives to the communities of which they are a part—the social worker interpreting the institution to the community.

TYPICAL CASE REPORT

Thus for the medical-social program in theory. I am going to close with a true story in which only the names are fictitious and which illustrates in actual practice some of the points discussed.

Mr. Mueller came to the chest clinic because he had seen a clinic notice on the factory bulletin board. He claimed he had no alarming symptoms, but thought it was a good chance to be examined. He was 33 years old, of German parentage and sturdy in appearance. He had worked in the foundry for the last 6 years. The doctor diagnosed him a suspicious case of tuberculosis and, following x-rays, urged him to go to a sanatorium as soon as possible. He shook his head and said it wasn't possible because he had a wife and five children, the oldest of whom was a girl of 12 who "wasn't very strong." The doctor then referred the case to the social worker who called at the home. The Muellers occupied a little cottage house on the outskirts of the city. Mrs. Mueller was apparently a hard worker for the home was clean and orderly and the children neatly dressed. Their total income was Mr. Mueller's weekly wage—$35. Their rent money each month was applied as instalments on the payment of their home. Aside from this mortgage they had no debts. But neither did they have any savings. When the worker

told Mrs. Mueller that the doctor advised sanatorium care for her husband, she did just what you and I might have done under similar circumstances. She broke down and cried. She had married Mr. Mueller when a young girl and thought she knew only how to keep house and bring up her children. She did not want to send them to an orphanage nor had she any relatives in this country to whom she could turn. Mr. Mueller had two sisters and one brother living in the city, but they had large families also, and were in no better circumstances. As she expressed it, they too were "just getting along." The worker assured Mrs. Mueller that all these things would be taken care of and that her immediate job was to help her budget their living expenses. Just how much was their rent? Did she make the children's clothes? How many tons of coal did they burn last winter? Did they have any insurance? After these and many other questions had been answered and a minimum budget worked out, arrangements were made through the social worker whereby the Department of Outdoor Relief contributed one-third, the Family Welfare Agency one-third and Mr. Mueller's employers one-third.* (See foot-note). The minimum budget for the upkeep of the home was thus assured for as many months of the husband's sanatorium care as were indicated.

In the meantime, Mr. Mueller's application for sanatorium care as a county charge was made to the court and the judge accepted the social worker's statement of the financial situation. When the contacts were examined, two of the children were found to have childhood tuberculosis and were recommended for a period of preventorium care. By this time the social worker had so gained the confidence of Mrs. Mueller that she made no objections when she advised her that Elsa and Adolph needed building up at the preventorium. A day later when the worker took her to see the institution, she was convinced that they would be happy there, so they went. During the next few months the worker kept in close touch with the patient in the sanatorium, the family carrying on back home and the children at the preventorium. Mrs. Mueller remembered that the social worker had urged her to make her visits to the institutions cheerful and she did this with a feeling of "playing the game" as it should be played.

At the end of six months, Elsa and Adolph were discharged from the preventorium looking plump, tanned and rosy. Mr. Mueller came home four months later as an arrested case. The social worker had interviewed his employer who had agreed to give him another job less arduous than his former, and one approved by the doctor.

That was three years ago. One morning the social worker met Mr. Mueller on his way to work. He grinned as he told her that the doctor who examined him regularly said he was O. K. "There aren't any bugs in my sputum", he proudly declared. The children are now a little older and Mrs. Mueller occasionally "works out" to stretch the family income. One of her employers tells an amusing story of Mrs. Mueller's attempt to educate her in the matter of diet. One noon she was preparing luncheon, which chanced to include pork chops, macaroni and baked potatoes. "It is no wonder you have those awful headaches, Mrs. Blank, when you eat only meat and starches", Mrs. Mueller remarked reprovingly. "We buy plenty of fresh fruit and vegetables—they are healthier and cheaper too. Why don't you try and see?"

* In this particular case the outdoor relief took the form of a Tuberculosis Pension. Since the enactment of the Children's Code, adequate relief may be provided by Mothers' Aid pursuant to that law.

ONE-HUNDRED TWENTY LICENSED

One hundred and twenty physicians were admitted to practice in Wisconsin as result of the June meeting of the State Board of Medical Examiners, according to Dr. Robert E. Flynn, Secretary. Of the total passed, twenty-eight were accepted by reciprocity and ninety-two passed the examinations of the Board. The June class was one of the largest in the history of the Board.

It is said that over 95% of the applicants presented premedical credentials of either a degree of Bachelor of Arts or of Science. The highest average in the examinations was attained by the only woman writing the examination, Dr. Gail F. Moxon who obtained a general average of 92%.

Dr. John E. Guy, Milwaukee, was elected as President of the Board and Dr. Robert E. Flynn, La Crosse, was re-elected Secretary.

SECTION ON RADIOLOGY

H. B. PODLASKY, M. D., Editor

Biliary or Renal Calculi

By R. P. POTTER, M. D.
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Marshfield

Shadows on a roentgenogram in the region of the kidney or gall bladder are usually easily distinguishable as either gall stones or kidney stones for each as a rule show some distinguishing characteristic in shape, arrangement of shadows and distribution of density which enables us to classify them as either renal or biliary. However, errors in diagnosis, both roentgenological and clinical, can and do occur and occasionally patients are operated on for gall stones when the stones are in the kidney and less frequently the kidney is operated upon when the stones are in the gall bladder, the errors in diagnosis being made because the roentgenogram had shown shadows of renal stones simulating gall stones and vice versa.

We know that either gall stones or kidney stones may be single or multiple and that both may occur in the same patient at the same time. Gall stones and kidney stones at the same time is probably rather an infrequent finding, yet one writer has reported five such cases.

In view of the fact that there is some doubt as to which we are dealing with in certain cases further study is sometimes necessary to make a differential diagnosis.

The following methods have been used: Stereoscopic films which more accurately locate the position of the shadow. The use of posterior anterior and anterior posterior views which will show kidney stones larger on the posterior anterior than on the anterior posterior views, and gall stones larger on the anterior posterior than on the posterior anterior views, but in very thin persons there is sometimes very little difference.

A pyelogram may be made and if the shadow is outside the pelvis and kidney shadow, renal stones may be ruled out. If the shadow is lost in the shadow of the pyelogram it may be superimposed and not be a kidney stone.

Fig. 1. Calculus in pelvis of right kidney which was removed December 7, 1927.

Cholecystograms are useful and if shadows are outside of the gall bladder shadow they are not gall stones. If the shadows are covered by the cholecystogram they are not positively gall stones unless they show displacement of the dye.

The lateral view is a very valuable aid as this shows the kidney stones in the kidney area described by Sgalitzer, which is covered by the posterior three-fourths of the bodies of the 12th dorsal, 1st and 2nd lumbar and occasionally the upper part of the 3rd lumbar and shows gall stones anteriorly to the bodies of the vertebrae.

ILLUSTRATIVE CASE

An illustration is given of a patient with a stone in the right kidney pelvis; the stone having a homogeneous density. In a few months the patient showed a stone in the

Fig. II. Pyelogram before removal of stone.

left kidney pelvis and three stones in the right side which had all the characteristics of gall stones. They were faceted, negative centers, with more dense periphery, while the shadow on the left side was homogeneous. The three shadows on the right side proved to be recurring renal calculi of entirely different density than the stone in the left kidney or the stone removed from the right kidney a few months previously.

Miss J. M., age 21, was operated August 16, 1927, for subacute recurring appendicitis. The appendix found was adherent to caecum and pointing toward the liver.

A few weeks later, November 1, 1927, patient returned having pain in right back and groin. On December 1, 1927, the roentgenogram showed a dense shadow in right upper quadrant which was diagnosed as a renal calculi in pelvis of the right kidney. On December 6th a pyelogram of the right kidney did not show the stone.

On December 7, 1927, roentgenogram showed calculus again, and at operation that day the stone was removed. Specimens of urine were examined occasionally following

Fig. IV. December 13, 1928. Rapid increase in size of stone on left side in four months.

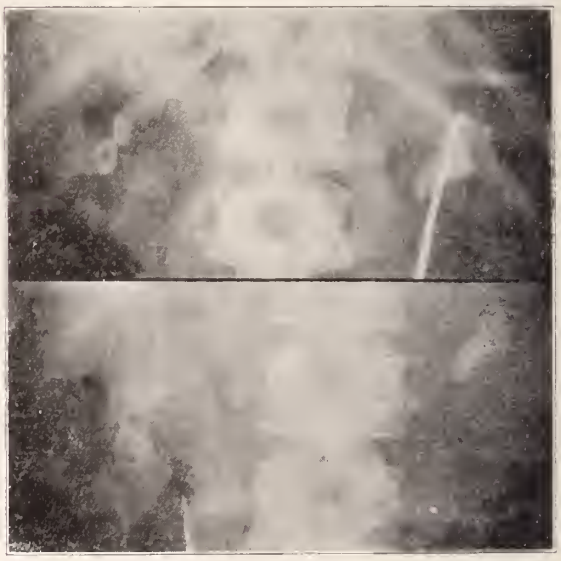

Fig. V. Upper film is anterior posterior view, lower film is posterior anterior view. Shadows are larger on posterior anterior view.

Fig. III. Roentgenogram eight months after removal of kidney stone on right side. Note three shadows on right and one on left side. August 4, 1928.

Fig. VI. Cholecystogram. Two of shadows outside of gall bladder shadow.

Fig. VII. Lateral view shows shadows in kidney region.

operation and after a few months pus and blood began to be found in increasing amounts.

On August 4, 1928, roentgenogram showed three shadows in right upper quadrant which had the usual characteristics of gall stones. They were faceted, had a dense outer rim and negative centers. There was also a dense shadow in the region of the left kidney, which appeared to be in the pelvis of the left kidney.

On December 13, 1928, roentgenogram showed the shadow on the left side very much increased in size, and from its shape and location was, no doubt, a stone in the left kidney pelvis.

The three shadows on the right side were about the same size as on previous examination.

December 15, 1928, stone was removed from pelvis of left kidney.

As there was some doubt whether the shadows on the right side were due to gall stones or kidney stones, we made posterior anterior and lateral views and a cholecystogram. The posterior anterior view showed shadows larger than the anterior posterior view and the lateral view showed shadows in the kidney region described by Sgalitizer. The cholecystogram showed two of the shadows entirely outside the gall bladder shadow.

On January 7, 1929, the stones were removed from the right kidney.

THE JOURNAL CLINIC

Carcinoid Tumors of the Small Intestine; With Case Report

(Multiple benign embryonal carcinoid tumors)

By GEORGE H. EWELL, M. D., and R. H. JACKSON, M. D.
Jackson Clinic, Madison

Our desire in reporting this case, aside from the rarity of the lesion, is to call attention again to the fact that although a lesion may be relatively benign in character, it may require a formidable surgical procedure to extirpate it, and that a surgeon who is not capable of coping with any pathologic lesion found should not consider himself qualified to do abdominal surgery.

Carcinoma of the small intestine is comparatively rare as it constitutes approximately 2½ to 3 per cent of all intestinal carcinomas and from 0.1 to 0.5 per cent of all malignancies according to Pack and Davis.

These authors also observe that the figures become more significant when one considers the large area of intestinal surface. The frequency of location increases as the stomach is approached above and the colon below. The age incidence is comparatively early, the average being about forty-five with many cases occurring between the ages of twenty and thirty. The majority are found in males.

Carcinoid tumors of the intestines are comparatively rare and belong to an interesting group of tumors first described by Lubarsch. They occur as single or multiple lesions, vary in size and are found in the jejunum, ileum and mesentery and probably in the appendix according to Ewing, and frequently in the obliterative type of appendix according to Pack and Davis. Grossly they are opaque, yellowish white tumors and are found in the mucosa or submucosa. In structure, according to Ewing, they form three groups resembling (1) pancreatic island tissue, (2) heterotopic intestinal mucosa and (3) Brunner's glands. For a review of the theories with regard to the histogenesis of these tumors, the reader is referred to the recent article of Pack and Davis. The resemblance to basal cell carcinoma of these tumors, as noted by Bunting, is interesting.

Microscopic pathology: The tumor cells occur in nests or cords with a tendency to pseudo-glandular formation, the latter is more common in the lower grade of malignancy and is more pronounced near the intestinal surface. The cytoplasm of the cell is moderate in amount and is variable in its staining reaction, reddish brown granules may be seen with ordinary stains. Intracellular lipoids have been demonstrated as well as argentaffine granules in the cytoplasm of these tumor cells, which is another very important reaction to differentiate them from true adenocarcinoma. This staining reaction is reported to be absent in some of the malignant carcinoid tumors and the granules tend to disappear when the tumor undergoes malignant degeneration. The nuclei are large, centrally located, oval or round, uniform in size and shape; they stain deeply and are rich in chromatin and have prominent nucleoli. The cell nests possess no supporting stroma and within the nests may be found many thin-walled blood vessels, another feature characteristic of carcinoid tumors. The muscularis is usually invaded down to the serosa, the latter being rarely invaded.

These tumors tend to grow slowly and remain localized; if found at operation local excision usually suffices. However, others may be the source of malignant neoplasms and produce extensive metastases in the lymph nodes and liver (Ransom). Gaspar recently reported a case of multiple carcinoid tumors of the jejunum with metastases into the mesentery and liver; one of these tumors caused intestinal obstruction. Clinically, they usually are without symptoms depending upon their size and location, and whether symptoms of obstruction or intussusception are produced; in these instances their nature may be suspected at the time of operation and the diagnosis confirmed by histologic examination.

CASE REPORT

A woman, aged 59, came to the Jackson Clinic October 23, 1928, complaining of attacks of acute abdominal pain. Her past medical and family history were irrelevant. For the past eight years attacks of acute abdominal pain, sharp and stabbing in character, have been present, always in the region of the umbilicus, nonradiating. There was an associated nausea and vomiting. The vomiting often lasted from a few hours to several days. Obstipation was present and followed subsidence of the acute pain; in the umbilical region pain remained as well as soreness to pressure. During attacks a ball-like swelling could be seen and felt by the patient to the right and below the umbilicus and gasses could be heard churning in the mass at this point. Two months previous to admission to the clinic attacks occurred frequently and there was a loss of 40 pounds in weight over a seven months' period. During the interval between attacks, she felt well.

Physical examination revealed a well developed, emaciated woman, weight 135; temperature, pulse and respiration were normal. Examination of the neck and thorax was essentially negative. The abdomen was flat except in the region of the umbilicus where the soft, ball-like mass described by the patient could be felt and which was considered to be a distended loop of bowel. The liver, spleen and kidneys were not palpable. The extremities were negative as well as examinations of the rectum and vagina.

Laboratory examinations: urine-reaction alkaline, specific gravity 1.012, albumin trace, sugar negative, few pus cells and urates 1. Erythrocytes 4,900,000,

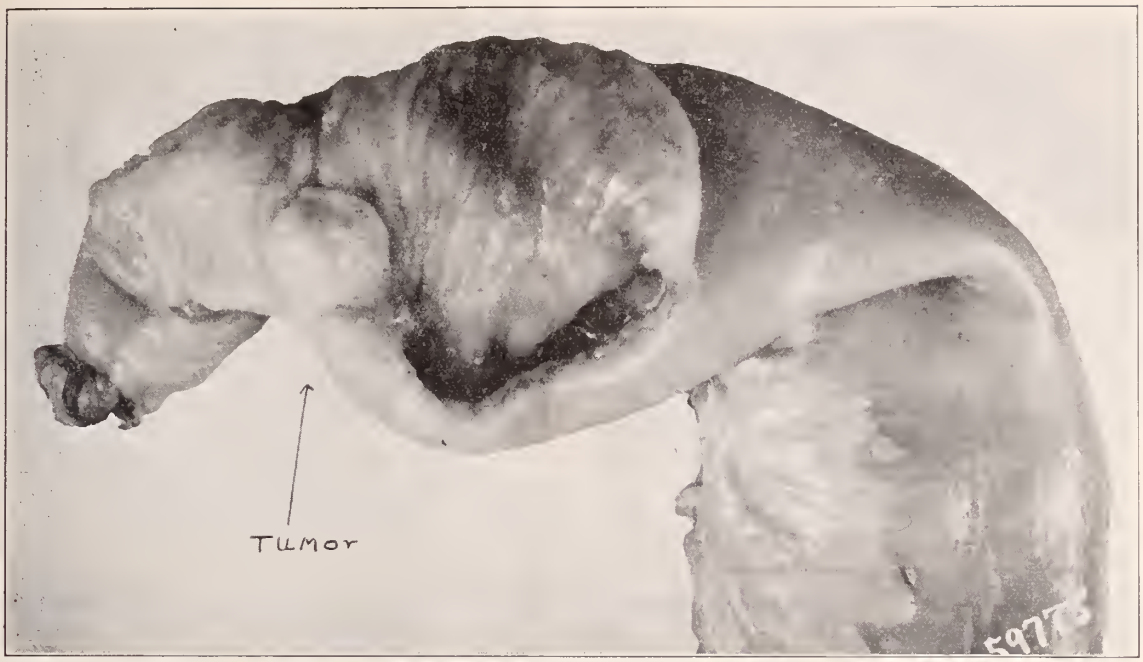

Fig. 1. Excised portion of bowel shows hypertrophied and thickened wall with rounded tumor mass.

leukocytes 7,250, hemoglobin 80 per cent, blood urea 50 mgs., chlorides 350 mgs., Wassermann negative, group IV.

Roentgen examination October 24, 1928. "Barium enema—no filling defect noted in colon. Ileocecal valve did not function readily, probably stenosis or spasm. Ileum at cecum somewhat dilated." October 29, 1928. Observation of barium meal—"colon fairly well filled with head of meal in rectum, one loop of small bowel was distended and retained moderate amount of barium. No lesion found but findings suggested partial obstruction around the ileocecal valve or low in the small intestine." October 30, 1928, the gastro-intestinal tract was empty.

A diagnosis was made of chronic, partial intestinal obstruction probably due to a Meckel's diverticulum. November 2, 1928, a laporatomy was performed by Dr. R. H. Jackson. In the terminal ileum about 4 inches above the ileocecal valve, there was a constricted area at which point through the bowel a firm tumor about 1 inch in diameter could be palpated, the constricted point did not impress one as being an infiltration from carcinoma or of the scirrhous type. The adjacent proximal 22 inches of ileum was greatly distended and the wall greatly thickened. The lymph nodes were not palpable and nodes or masses could not be felt in the liver. The pelvis was negative. The thickened, distended ileum with the tumor-bearing area was resected to within 2 inches of the ileocecal valve, the ends invaginated and a lateral anastomosis done. Convalescence was uninterrupted except for a wound infection which developed on the eighth postoperative day with a chill and temperature of 103.5° F. On the eleventh postoperative day the temperature and wound infection gradually subsided and the patient was discharged the twenty-first day after the operation.

Pathologic Report: The wall of the excised portion of the bowel was greatly thickened (Fig. 1) and the vessels congested. The mucosa, except for congestion and thickening, was normal and intact. A tumor 1 by 1 by 1 inches was found which was firm and grayish white, the mucosa surrounding was intact. The microscopical pathological sections examined presented nothing of importance different from

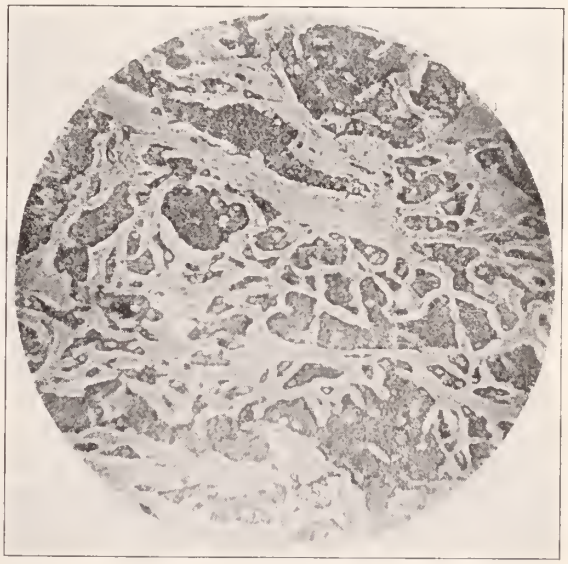

Fig. II. Shows cords and nests of tumor cells with tendency to pseudo-glandular formation. (x 12).

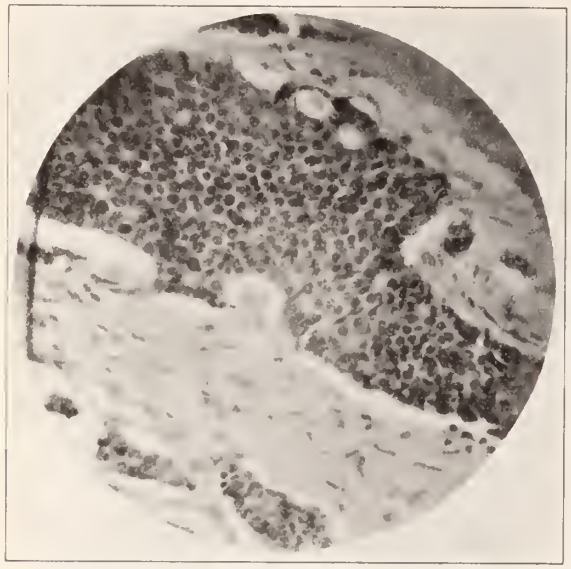

Fig. III. Shows character of tumor cells and their nuclei. (x 62).

Fig. IV. Shows infiltration of tumor cells into the muscularis. (x 12).

the general pathological description of these tumors which has already been given. (Figs. 2, 3 and 4). The original diagnosis of carcinoid tumor was made by Dr. C. H. Bunting, Professor of Pathology, at the University of Wisconsin.

She remained well until the middle of April, 1930, when she was seen in consultation in a neighboring city by Dr. H. E. Marsh of our medical staff. For two weeks prior to his visit she had suffered from severe pain across the lower portion of her back, also vomiting. The pain later localized to the left side of the back in the region of the eighth or ninth vertebra and radiated to the front. The pain was severe enough to require morphin, grains one-sixth (gr. 1/6) daily. The vomiting had subsided.

Physical and laboratory examinations at that time were negative. The possibility of recurrence with metastases was most probable and the patient was advised to come to the clinic for study. A later communication stated that the pain had subsided.

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Infantile Paralysis; Symptoms

PREPARED BY THE WISCONSIN STATE BOARD OF HEALTH

Stage 1. A systemic invasion, like other acute infections showing fever usually of low grade and gastric enteric manifestations. The patient is likely to be drowsy and at the same time irritable. Either constipation or diarrhea exists. Vomiting is likely to occur only once or twice. A few cases have sore throat or congested feces. Sometimes these symptoms last a day or two and clear up only to be followed by involvement of the nervous system. No increased spinal fluid cell count at this stage. Due to similarity of other troubles no more than a reasonable suspicion can be entertained if the symptoms proceed no further.

Stage 2. Indicated by involvement of nervous system such as stiff neck which is usually not as pronounced as in meningitis,

muscular twitchings, tenderness along spine as shown by bending, hyperesthesia, or tenderness, local pains somewhere in body as shoulder or neck and exaggerated reflexes. Increased cell count above ten in spinal fluid, usually between fifty and two hundred fifty.

Stage 3. Paralysis of one or more muscles.

Remarks: Above symptoms refer to the more typical cases and usually only a part of the above symptoms are present. The stages as above outlined may run consecutively or be super-imposed upon each other. Paralysis usually intervenes at one to seven days or even later but commonly comes on in the second to fourth day. There is a great varient in intensity of symptoms from mild slightly ill cases having little or no paralysis to intense and fulminant forms having paralysis almost at the start. A number of other symptoms referring to the nervous system are called attention to usually existing singly in different cases. Flushed appearances of the face, bright eyes, backache, and cerebral tache are prominently mentioned. Serious cases point definitely to involvement of the higher nerve centers.

Anterior Gastroenterostomy; Case Reports

By W. J. TUCKER, M. D.
Ashland

We have been instructed for years in text books and by surgical teaching that anterior gastroenterostomy is technically incorrect and practically unworkable. Logically speaking, if the stomach drained solely by gravity placing the gastrojejunal opening at the most dependent portion of the stomach and therefore posterior, it would be the technically correct thing to do. Actually, however, the stomach empties by muscular contraction and therefore would force fluids out of any opening, no matter where it is placed.

Often we are confronted at the operating table with technical difficulties that make a posterior gastroenterostomy, that is to say, doing the gastrojejunotomy through the lesser omental cavity, impossible or dangerous. Such a situation often arises in a posterior ulcer perforation onto the pancreas or in a malignant infiltration where a palliative gastroenterostomy is indicated. Two cases will illustrate:

H. B. had an exploratory laparotomy and he was found to have an extensive perforated ulcer on the back wall of the stomach. The stomach was widely bound down by firm adhesions and it was felt that a resection would be unwarrantedly dangerous. The jejunum was brought forward to the transverse colon and anastomosed 12 to 15 inches from the duodenal jejunal angle with the lower anterior wall of the stomach. At the present writing, 3 years later, patient has a perfect functioning stoma with complete relief of symptoms.

The second case, P. O. 60 years old. Exploration revealed a large mass involving the pylorus and lower portion of stomach and perforation posteriorly, thought to be malignant. There was complete obstruction. An anterior gastroenterostomy was done and patient sent home to die in six months. At this writing, 2 years later, patient is alive and well with a perfect functioning stoma,—undoubtedly a perforating ulcer.

I am not advocating it as a routine procedure. Posterior gastroenterostomy is the operation of choice, technically, and anatomically correct. But, when circumstances arise making the posterior operation impossible or dangerously difficult then an anterior gastroenterostomy can be done and expected to function successfully. The jejunal loop should be 12 to 15 inches long and turned to the right as distinct from the posterior operation where it is turned to the left. The opening should be made as near the pylorus as possible and low on the anterior wall.

COUNCIL AWARD THURSDAY EVENING

Awards by the Council to members whose service to the public and profession has been of an unique and understanding character, will be made by Dr. Arthur Rogers, chairman of the Council, at the opening of the Thursday evening session, September 10th. The reward is a small gold replica of the seal of the State Society. Established a year ago, its first recipients were Dr. C. A. Harper, Madison, and Dr. John M. Dodd, Ashland. It is understood that three will receive the award this year.

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EDITORIALS

WITHOUT ECONOMIC ORGANIZATION—?

ARE we doctors doing our economic thinking as though we were living in the "saddle-bag days of medicine?" Such a suggestion has come from Ray Lyman Wilbur, past president of our American Medical Association, Secretary of the Interior, and chairman of the Committee on the Cost of Medical Care.

"Physicians being strong individualists," said Dr. Wilbur, "dealing intimately with personalities and following the ideal of the best good of the patient, find it almost impossible to turn from their busy lives to economic things; and yet without economic organization the physician cannot prosper and all our people cannot receive the benefits that they should from modern science and modern medicine. * * * Our real difficulty is that we carry with us much of the economic thinking of the saddle-bag days of medicine."

As a solution, Dr. Wilbur declares for the application of those principles of organization which have built up the industrial life of our nation.

We respect the opinion of Dr. Wilbur as that of a physician able to think of the health of over a hundred million people and without excluding the 156,440 physicians in the United States from his thinking, and of their indispensability from any health program. Nevertheless, we wonder—in view of the present massive collapse of mass production in industry—if, after all, industrial managers have offered an example for us to follow.

We agree with Dr. Wilbur that we have not been doing enough advanced thinking. Too frequently we have allowed less well qualified, but more articulate, more blatant "leaders" to walk out in front of us. *But leadership should be the prerogative of the best thinkers,* of those who have the most information. And who should know so much of medicine, so much of personal and public hygiene as physicians?

We face important problems that press for a proper public solution. To these we must give our best thought in county as well as state meetings. We shall remain in the saddle-bag days forever if we say to ourselves that there will be no change in "our

THE PHYSICIAN IN COURT

IN MANY respects the physician's position when called into court as a medical witness is not a particularly pleasant or happy one. He is often called on short notice with little or no opportunity to study the questions at issue to give an opinion upon mooted or intricate problems arising in the trial of personal injury or criminal cases. He is sometimes asked to answer long hypothetical questions which are frequently loosely constructed and so contradictory within themselves that any positive or definite answer he may give without qualification may be con-

strued by the attorney in any way that best suits his purpose in building up a case. He may be asked to give testimony in cases in which his own patients are parties to a suit and, if he gives an opinion unfavorable to his former patient's interests, he is liable to be accused of "throwing down" his patient or "selling out" to some corporation and thereby makes enemies of those who were formerly part of his clientele. He is occasionally called into court and, while waiting to give testimony, is obliged to listen for hours sometimes to attorneys asking and repeating many times ill-digested and often meaningless questions. All this is disconcerting and time-consuming and, on the whole, an ordeal that probably most medical men would be glad to escape.

On the other hand, the physician has to remember that by virtue of his training and education he is supposed to be in possession of certain knowledge often quite essential to the purposes of the courts and that he is rendering a definite service to the court by placing at its disposal that information which he alone can give. J. F. S.

MISSED CASES OF TUBERCULOSIS IN GENERAL HOSPITALS

ACCORDING to the Framingham survey, there are twice as many undiagnosed cases of tuberculosis in an average American community as diagnosed cases.

Is it any wonder, then, that tuberculosis is ever present in general hospitals, in spite of frequent rules against admission of tuberculous patients? Patients enter general hospitals constantly with other disease conditions who also have an active or latent tuberculosis unknown either to themselves or to their physicians. Unless a careful chest examination is made, with tuberculin tests, x-rays and repeated sputum analyses, these tuberculous patients may remain "missed" throughout their hospital stay. Not practicing the ordinary hygienic precautions of informed and intelligent tuberculosis patients, they are apt to be most dangerous as spreaders of this disease.

In addition, surgery, we know, may frequently light up a minimal active or occult tuberculosis, especially when ether is used as an anesthetic. Thus a missed case of tuberculosis in a dormant stage, given an appendectomy with ether, may reactivate and spread to new areas. Nurses and attendants are easily infected, and if massive doses of tubercle bacilli are taken into their bodies, not only infection but disease may develop. Particularly is disease likely to follow if their resistance is lowered.

Three things should suggest themselves to every physician and hospital authority on the ever present problem of tuberculosis in the general hospital:

(1) The possible presence of tuberculosis in every case brought to the hospital with acute medical or surgical disease must be kept in mind.

(2) Develop a communicable disease technique for all suspicious cases of tuberculosis and other infectious disease, which would be as efficient as the aseptic technique of the operating room.

(3) Apply this technique to every case which may be "known" as appendicitis, for example, but in whom an "unknown" suspicious tuberculosis may also exist. A. A. P.

SCIENTIFIC INTEREST

THE atmosphere of the recent (Twenty-Seventh annual) meeting of the National Tuberculosis Association seemed to this observer to be surcharged with scientific medical interest. Never hitherto was the attendance so large. Never before were there present so many prominent physicians, biologists, bacteriologists, chemists and other workers in the medical sciences.

We have observed enthusiastic and forward-looking programs and plans before, but they have been for the most part among the social workers, organizers and promoters. This year, it was the research workers in the laboratory and clinical field who exhibited and inspired most of the restrained excitement. There was an air of expectancy as if we are on the eve of an epoch marking announcement of an epoch making discovery in medical science.

These may not be such bad times after all. H. E. D.

THE PRESIDENT'S PAGE

C. A. Harper

NINETIETH ANNUAL MEETING

THE Ninetieth Annual Meeting of the Wisconsin State Medical Society is close at hand. Certainly when the program for this meeting is studied no special emphasis need go forth concerning the importance of such meeting to every physician that can possibly attend.

Progressive and scientific medicine has always been the watchword of the Wisconsin physicians. The annual meetings have been an important factor in maintaining this high standard. Undoubtedly in the past more attention has been given to the scientific phases of medicine than to the economic welfare of the profession as a whole. There is no doubt but that both avenues of the problem can be traversed along constructive lines with increased benefit both to the public and to the profession. It might be said that the profession has been so ethical as to be unethical so far as the welfare of the masses is concerned.

No great profession has such valuable, marketable wares as the medical profession, which is largely verified by the program of the Ninetieth Annual Meeting. The question may arise whether the commercialization of scientific medicine in the future will be directed by an educated, organized medical profession or will be left to the "emotions" and "instincts" of the masses that mean well but are incapable of scientific deductions. The time is at hand to clear the horizon of combinations which, if not partly directed, may become serious. The good fellowship so wonderfully manifested at the annual meetings will be a material factor in obtaining a better understanding of the problems confronting organized medicine and devising ways and means of directing a satisfactory solution to a profession that has been trained in the science of medicine.

The Ninetieth Annual Meeting therefore is important not only scientifically but economically as far as the future of medicine is concerned. Every physician should prepare himself to do his part. You need the state meeting and the state meeting needs you.

Under existing conditions we hope that this plea may have some justification rather than criticism. Each physician of the state should come prepared to do his part in discussion of the general program. He should also give thought and consideration to those conditions that will materially aid in directing scientific medicine along the proper channels. During this period of governmental unrest which in so many countries has been plainly manifested, we are not so sure of the noncontagiousness of such a procedure and the advent of similar programs in the United States.

The science of medicine is too vitally important for the public welfare to be handicapped in any of its advancements or its applications. No doubt but that the careful thinking citizen looks to the medical profession to safeguard the science of medicine and therefore render that service to humanity which only the medical profession can render.

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SOCIETY PROCEEDINGS

BROWN-KEWAUNEE

On July 25th, the Brown-Kewaunee County Medical Society held an afternoon and evening meeting at the Old Fort Howard Hospital at Green Bay. The occasion being the official medical dedication of this old hospital where the great Dr. Beaumont worked and carried out his experiments upon his patient, Alexis St. Martin, the French Canadian voyageur.

This building has been bought by the city of Green Bay, renovated and reconstructed so that at present it is a beautiful building and monument to commemorate the work of Dr. Beaumont.

The afternoon program consisted of musical numbers by Mr. Robert Lynch and Mrs. Nelson. Mr. W. T. Hewitt of the Oshkosh State Teachers College, gave a talk in his very interesting way and was very much enjoyed by everybody. Dr. T. J. Oliver of Green Bay, gave the early medical history of Brown County. Dr. Oliver has made a very extensive study of this subject and his talk was highly appreciated by the audience.

At 5:30 P. M. luncheon was served by a committee of doctors' wives consisting of: Chairman, Mrs. O. E. Stiennon, Mrs. W. E. Mueller, Mrs. J. J. Bellin, Mrs. T. J. Oliver, Mrs. P. R. Minahan, Mrs. J. L. DeCock, Mrs. L. D. Quigley, Mrs. O. W. Saunders. The afternoon meeting was open to the general public and the old building was filled to its capacity.

The evening meeting began at 7:30 P. M. and consisted of musical numbers and a talk by Dr. Otho Fiedler, president-elect of the State Medical Society. He paid a tribute to Dr. Beaumont and gave a very clear word picture of the difficulties under which the physicians of Dr. Beaumont's time worked, enumerating the few drugs and surgical instruments which were in use.

Dr. P. R. Minahan of Green Bay, discussed Dr. Beaumont from the standpoint of the soldier and in his talk traced his career from the time he entered the service of the U. S. Army until his services were ended.

The principal speaker of the evening was Dr. C. A. Harper of Madison, President of the State Medical Society. He paid a tribute to the great work of Dr. Beaumont and also to the organization which sponsored the restoration of the Old Fort Howard Hospital as a perpetual monument to the work of Dr. Beaumont. He also discussed some of the outstanding needs of the medical profession of today.

The Brown-Kewaunee County Medical Society expresses its appreciation to those men who helped to make the meeting a success. E. S. K.

CLARK

A meeting of the Clark County Medical Society was held at Owen on July 29th. Golf was played in the afternoon at the Owen Country Club. In the evening a sumptuous chicken dinner was enjoyed by the members and their guests, following which a paper was read by Dr. S. E. Williams of Chippewa Falls, on "The Diagnosis of the Surgical Abdomen." A very lively discussion followed, led by Dr. Joseph Smith of Wausau and Dr. H. H. Christofferson of Colby. Dr. James Vedder, Marshfield, discussed the paper as it applied to children.

Dr. E. L. Sevringhaus, Madison, read a paper on "A Simple Plan for the Treatment of Diabetes Outside a Hospital." This paper was also appreciated very much by all those present. The discussion was led by Dr. H. H. Milbee of Marshfield.

Every town in the county was represented. A. L. S.

DANE

A special meeting of the Dane County Medical Society was held at the Madison General Hospital, Friday, August 7th, at eight p. m.

Talks on the subject of Acute Anterior Poliomyelitis were made by the following:

General Remarks by Dr. C. A. Harper.

Epidemiology by Dr. H. M. Guilford.

Symptoms and Diagnosis by Dr. J. E. Gonce.

Convalescent Serum by Dr. W. D. Stovall.

Case Reports by Drs. R. T. Cooksey and A. W. Bryan.

POLK

The regular monthly meeting of the Polk County Medical Society was held at the home of Dr. R. G. Arveson, Frederic, on August 23.

Mr. Theodore Wiprud, Secretary, Milwaukee County Medical Society, gave a talk on "Medical Practice in a Changing World". Particular emphasis was placed on the subjects of "State Medicine" and "Periodic Health Examinations".

Dr. J. D. Nicholson gave the medical topic "Some Practical Phases of Obstetrics".

The Society decided to sponsor a program devoted to the subject of periodic health examinations and to invite the members of the Barron and St. Croix County Medical Societies in Wisconsin and the Pine-Chisago County Medical Society of Minnesota to attend the meeting.

ROCK

A play day, with golf and bridge as diversions, was sponsored by the Rock County Medical Society at the Beloit Country Club on Wednesday afternoon and evening, July 29th. Forty members of the Society, as well as the Woman's Auxiliary attended. Prizes were awarded for events. A six-thirty o'clock dinner was served. Drs. F. A. Thayer, H. A. Raube and F. E. Brinkerhoff, all of Beloit, were in charge.

NEWS ITEMS AND PERSONALS

Dr. J. W. Tanner and Dr. S. L. Henke have been added to the staff of the Midelfart Clinic, Eau Claire.

Dr. Tanner is a graduate of Rush Medical College and has been resident physician at Cook County hospital and at Presbyterian hospital, Chicago. He was also a former instructor of ophthalmology at Rush Medical College.

Dr. Henke is a graduate of the Medical School of the University of Wisconsin and was formerly house physician at Research hospital, Kansas City, Mo.

Dr. Tanner will specialize in eye, ear, nose and throat diseases while Dr. Henke will limit his practice to skin diseases.

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Dr. C. E. Stubenvoll of Shawano was the guest speaker at a meeting of the Lions Club held at the Country Club, Clover Leaf Lakes, Clintonville.

—△—

Dr. and Mrs. Stuart McCormick, Madison, and Dr. and Mrs. F. C. Richmond, also of Madison, returned the latter part of July from a trip to Sioux Ste. Marie, Ontario.

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Green Bay physicians were defeated by the Green Bay dentists in their annual golf match at the Oneida Golf and Riding Club on July 25th. The score was close, ending 14 to 13 in favor of the dentists. The Nasau system of scoring was used with ten members of each profession playing on each side in match play. Dr. D. F. Gosin was medalist with a score of 88. The following physicians played: Drs. D. F. Gosin, J. J. Robb, W. P. Tippet, R. L. Cowles, W. H. Bartran, W. E. Fairfield, R. W. Kispert, A. J. McCarey, W. W. Kelly and E. W. Exley.

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Articles of incorporation were filed on July 23rd with the Secretary of State for the Madison Neurological Clinic, Inc. The incorporators are Drs. W. F. Lorenz, W. J. Bleckwenn and H. H. Reese.

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Dr. Gustave Windesheim, president of the State Board of Health, was speaker on the program given for the Orthopedic Sunshine Camp pupils at Kenosha on July 23rd.

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Dr. Louis J. Pritzker, formerly of Chicago, has opened offices in the Schwartz building, Kenosha, his practice being limited to gynecology and operative obstetrics.

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Dr. and Mrs. Damon Brown, Madison, vacationed in northern Wisconsin in July.

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Dr. C. M. Gleason of Manitowoc told members of the Kiwanis Club of Manitowoc of his recent trip east at one of the Club's meetings in July. Dr. Gleason made an extended trip and each week attended a meeting of Kiwanians. He visited clubs at Philadelphia, New York, Bangor, and Buffalo.

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Dr. W. J. Irvine of Manawa received severe injuries in an accident when the car which he was driving collided with a truck on highway 22 near the county farm.

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Dedication ceremonies of old Fort Howard hospital in Green Bay were carried out under the direction of the Brown–Kewaunee County Medical Society on Friday, July 24th. The program included afternoon and evening entertainment. In the afternoon Prof. W. C. Hewitt of Oshkosh State Teachers College gave the main address, while Dr. T. J. Oliver of Green Bay spoke on the history of the old hospital.

Dr. C. A. Harper, president of the State Medical Society, was the principal speaker of the evening. Other speakers were Dr. Otho Fiedler, Sheboygan, president-elect of the State Society, and Dr. P. R. Minahan of Green Bay.

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The annual Mississippi Valley Conference on Tuberculosis will be held in Hotel St. Paul, St. Paul, Minnesota, September 21 and 22.

Dr. Wm. S. Middleton, associate professor of medicine, University of Wisconsin, is scheduled to give a case report on the first day's program, while Dr. Hoyt E. Dearholt, executive secretary of the Wisconsin Anti-Tuberculosis Association, will discuss a paper by Miss Marquerite A. Ridler, director of social service, Glen Lake Sanatorium, Oak Terrace, Minn.

Dr. Oscar Lotz of the Wisconsin Anti-Tuberculosis Association, will present a paper on "Is a Good History 50% of the Diagnosis in Tuberculosis?" at this meeting.

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Dr. R. J. Portman, formerly of Antigo, has opened an office in the Kresge building in Appleton.

Dr. L. S. Eagleburger, Waupun, was confined to his bed the latter part of July because of an injury to his back.

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Doctors Eugene and I. K. Krohn of Black River Falls are having a new clinic building erected on the site of their former office building. It will be a one-story, brick building. The interior arrangement will provide for three private offices, reception room, operating room, and rest room.

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Construction work on the new Memorial hospital at New London, which had been delayed for several months, has now been started. A bond issue of $50,000 has been underwritten by a Green Bay Company. It is expected that the building will be completed in about two months.

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Dr. George H. Williamson of Neenah spoke before a meeting of the Neenah Rotary Club, describing his travels through England, Germany, France and Austria.

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Dr. Walter E. Meanwell, basketball coach University of Wisconsin, returned recently from Los Angeles where he made movies similar to those made by the late Mr. Knute Rockne.

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Heat prostrations brought death to 194 persons in Wisconsin in June, as compared with but two deaths from this cause in the previous June according to an announcement by the bureau of vital statistics, State Board of Health.

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The office of Dr. C. L. R. MacCollum of Manitowoc was robbed of $300 in cash and valuables by a young man and woman confederate. A telephone call was made by the pair to summon Dr. MacCollum's assistant to a neighboring office and while she was there talking to the woman who pretended to be making an appointment, the young man slipped back into the office taking the money and jewelry.

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A baby clinic was sponsored by the Outagamie County Medical Society at the Appleton Woman's Club on July 28th. It is planned to hold these clinics each month.

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Dr. H. L. Greene has opened an office in the First Central building, Madison, for practice in orthopedics and fractures. Dr. Greene is a graduate of the University of Oregon School of Medicine in 1928 and served internship in the Wisconsin General Hospital, Madison. For two years he was resident physician at Wisconsin General under Doctors F. J. Gaenslen and R. E. Burns. Dr. Greene recently returned from Milwaukee where he served in Dr. Gaenslen's office during the absence of Dr. Blount in Europe.

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Dr. A. H. Nainka, formerly of Gleason, has moved to Dalton, Wisconsin, to engage in practice there.

Dr. C. A. Sholtes of New Orleans on August first became associated with Doctors Coumbe and Dull of Richland Center. His practice will be limited to eye, ear, nose and throat diseases. For the past two years, Dr. Sholtes has been interne and house surgeon at the Eye, Ear, Nose and Throat Hospital at New Orleans.

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Dr. C. A. Armstrong of Prairie du Chien and Dr. A. Milton Cox of Albany visited the offices of the State Medical Society in Madison the early part of August.

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Dr. H. E. Kasten of Beloit is at present pursuing post-graduate studies in urology at Vienna. At the conclusion of his work there he will visit Budapest, Berlin and Paris for further study.

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Dr. C. S. Hayman, Boscobel, returned the middle of August from Chicago where he did six weeks post-graduate work. Dr. Hayman is a member of the Sheboygan Clinic, other members of which are: Drs. E. H. Spiegelberg, E. F. Freymiller and J. C. Betz.

MILWAUKEE

Rocky Knoll Sanatorium at Plymouth recently celebrated its fifth anniversary. The sanatorium is the Sheboygan County institution for the care of the tuberculous. Talks were given by Dr. Hoyt E. Dearholt, executive secretary and Dr. Oscar Lotz of the medical department of the Wisconsin Anti-Tuberculosis Association.

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Dr. and Mrs. C. G. Johnson recently returned from a five-week trip to northern Canada, Alaska, and Washington.

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Dr. J. S. Stefanez, after touring Canada, is vacationing in the Land o'Lakes region in Wisconsin.

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Dr. Edwin Henes, Jr., whose family is spending the summer abroad, spent several weeks in northern Wisconsin.

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Dr. Dexter Witte and family enjoyed a vacation at Big Cedar Lake, Wisconsin.

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Dr. and Mrs. Walter J. Winnemann and daughter Doris, have returned to Milwaukee after spending some time in Merrill, Wisconsin.

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Dr. Arthur J. Patek with a group of friends left the latter part of July for a camping trip at Jasper Park in the Canadian Rockies. They expect to return about September 1st.

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Word has been received that Dr. Nicholas Murray Butler, President of Columbia University, in New York City, will be unable to attend the International

Assembly in Milwaukee in October. As President of the Carnegie Endowment for International Peace, Dr. Butler's presence at an important international meeting in this connection is imperative. Since Dr. Butler was to have been the principal speaker at the final session of the Assembly, as well as speaker of the evening at the banquet to be held the same day, keen disappointment is felt by everyone connected with these meetings at Dr. Butler's withdrawal.

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A meeting of the special committee on the Care of the Indigent was held in the Mariner Tower on July 31st. The purpose of the meeting was to discuss a tentative plan for the care of the Milwaukee County indigent by all of the physicians of the Medical Society of Milwaukee County. This would necessitate the abolishing of the present district-physician system. The next meeting of the Committee will be held with Mr. W. L. Coffey, manager of the County Institutions, and representatives of the medical staff of the county institutions.

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Interviews with citizens of Milwaukee are being broadcast weekly over The Wisconsin News radio station WISN. On August 7th, Mr. Theodore Wiprud, executive secretary of The Medical Society of Milwaukee County, discussed the value to the public of the Physicians' Service Bureau.

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Dr. W. J. Carson recently addressed the Lions Club on "Modern Surgery."

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Dr. and Mrs. Wilbur LeCron had as their guest during the latter part of July, Dr. F. Leslie LeCron of Baltimore.

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Dr. and Mrs. Harold W. Shutter sailed on August 8th from New York for Europe where they expect to spend some time traveling.

BIRTHS

A son to Dr. and Mrs. David Wigod, Milwaukee, on July 25th.

A son to Dr. and Mrs. C. J. Corcoran, Milwaukee, on Judy 25th.

A daughter to Dr. and Mrs. John B. Wilkinson, Oconomowoc, on July 20th.

ENGAGEMENTS

The engagement of Dr. Arthur J. Patek, Jr., to Miss Mary Marian of Boston, has been announced. Miss Marian was a recent visitor in Milwaukee where she was the guest of honor at many social functions.

MARRIAGES

Dr. Patrick L. Callan, Milwaukee, to Miss Kate Crawford, Milwaukee on July 22nd in Marquette University Chapel.

Dr. Florian F. Zboralski, Manitowoc, to Miss Mary Jane Bolger, Minocqua, at Minocqua on August first.

Dr. L. F. Corry, Weyauwega, to Miss Ann Kathleen Burke at Rochester, Minn., on August 3rd.

DEATHS

Dr. W. N. Moore, Appleton, died on July 25th at his home after a six months' illness.

He was born near Gotham, Richland County, July 14, 1883, and was a graduate of Northwestern University Medical School in 1909. He practiced in Chicago for one year and for a time was traveling division surgeon for the Chicago, Burlington and Quincy railroad. In 1913 he came to Appleton. Between 1916 and 1917 he served as military surgeon on the Mexican border with the National Guard, and the following summer served on the exemption board. He enlisted in 1917, and was overseas with the army of occupation until June, 1919. Dr. Moore then returned to Appleton and was associated with Dr. Joseph L. Benton from 1920 to 1924, and in July, 1924, became associated with Dr. C. J. Neidhold.

Dr. Moore was a member of the Outagamie County Medical Society, the State Medical Society and the American Medical Association. He was also a member of the staff of St. Elizabeth hospital and a member of the Interstate Post-Graduate Medical Assembly.

He is survived by his father, one sister and two brothers.

Dr. G. M. Steele, Oshkosh, President of the State Medical Society in 1886, died on August first following a long illness.

Dr. Steele was the oldest practicing physician and surgeon in the city of Oshkosh, having practiced in that vicinity for the past sixty years.

He was born August 23, 1847, in St. Lawrence County, New York, and was a graduate of Columbia University College of Physicians and Surgeons, New York City, in 1871.

Dr. Steele was a member of the Winnebago County Medical Society, the State Medical Society, and the American Medical Association. He was also a member of the Radiological Society of North America.

Dr. Charles F. King, Hudson, died on July 20th at his home after an illness of two weeks. His health had been failing for some time, having given up the active practice of medicine two years ago, although still continuing his duties as Hudson's health officer.

Dr. King was born in the year 1844 in Buffalo, New York, and had been a resident of Hudson for almost sixty years. He was a graduate of Rush Medical College in 1873. Dr. King served with the 3rd Wisconsin Cavalry in the Civil War and was surgeon of the 4th Wisconsin Infantry in the Spanish–American War, retiring with the rank of major.

He was elected to honorary membership in 1921 in the Pierce–St. Croix County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his widow, one son and two daughters.

Dr. S. E. Hutchins, Trempealeau, died on July 19th at Rochester, Minnesota.

Dr. Hutchins was born in the year 1867 near Independence, Trempealeau County, and was a graduate of Rush Medical College in 1892. For many years he practiced medicine in Independence and later in Whitehall. During the World War, Dr. Hutchins was a major in the medical corps.

He is survived by his widow and two daughters.

Dr. Marion L. Robey, Edgar, died on July 17th.

Dr. Robey was born in the year 1855 and was a graduate of Rush Medical College in 1886. He had practiced medicine in River Falls and Grantsburg before coming to Edgar.

Dr. William H. Pugh, Kenosha, died on August 1st at his home in Kenosha.

Dr. Pugh was born in Milberton, Ontario, Canada, April 26, 1863. He was a graduate of University of Toronto Faculty of Medicine in the year 1890. He practiced in Hamilton, Ontario, for a time before coming to Kenosha in 1892.

He is survived by his widow.

Dr. John W. Cutler, Milwaukee, died on August 2nd.

Born near Smithville, Canada, in 1850, he taught at the country school there and entered the ministry. Later he came to Chicago and entered the Hahnemann Medical College and Hospital, graduating in 1886. He then practiced in Platteville until 1892 when he went to Vienna for further study. He settled in Milwaukee upon his return. He was medical examiner for the Milwaukee road.

He is survived by his widow.

SOCIETY RECORDS

NEW MEMBERS

F. F. Zboralski, 926 So. 8th St., Manitowoc.

Samuel J. Faber, 1501 Washington Ave., Racine.

G. S. Flaherty, Burlington.

G. C. Chamness, J. I. Case Hospital, Racine.

George M. O'Brien, 1019½ Milwaukee Ave., S. Milwaukee, Wis.

C. N. Dawson, Beloit.

F. M. Corry, Menasha.

B. I. Brindley, Wisconsin General Hospital, Madison.

F. J. Diamond, Loyal.

Sarah D. Rosekrans, 170 Hewett St., Neillsville.

M. C. Rosekrans, 170 Hewett St., Neillsville.

E. C. Quackenbush, 519 Garland St., Sturgeon Bay.

Changes in Address

F. O. Zillessen, Fond du Lac, to Easton City Hospital, Easton, Pa.

T. L. Johnston, Racine, to 186 Portland Ave., Wauwatosa.

R. R. Jandrain, Wayside, to Abbotsford.

K. W. Emanuel, Niagara to 56th and Grand Avenues, Duluth, Minn.

Resignations

G. H. Kriz, 204—11th St., Milwaukee.

Possibility that millions of dollars may be collected for Wisconsin Indians was discussed here when Frank W. Kuehl, assistant attorney general, began his investigation of the validity of claims of Wisconsin Indians against the United States Government. Under a law passed by the last legislature, and recently signed by Gov. La Follette, a complete survey of this problem is to be made by Kuehl, who has been appointed by Attorney General John W. Reynolds to conduct this investigation.

* * *

Wisconsin citizens will continue to pay their real estate taxes in January. Gov. La Follette failed to sign the Tremain bill providing for the semi-annual payment of taxes. This bill went through the legislature with little opposition. It was one of the few measures on the Governor's desk at the time of adjournment.

* * *

That bow legs may be due to the small but significant thyroid gland located in the neck, is the theory of Prof. Michael F. Guyer of the zoology department of the University of Wisconsin, who lectured at Davenport, Iowa, recently. The address was given before the Iowa academy of science.

* * *

The county is not liable for the expense of caring for a county jail prisoner in a hospital, such prisoner not being a "poor person", F. M. Wylie, dep-

uty attorney general held in an opinion to the district attorney of Iowa County.

* * *

F. C. Seibol, assistant attorney general in an opinion to the district attorney of Oconto County held that a city is without power to issue bonds to provide funds for current expenses or for poor relief.

* * *

A card used in the sale of spectacles in stores containing advertisements and certain numbers opposite printed matter grouped according to the size of the type indicating what spectacles to buy for each group, is a violation of our optometry law, according to J. E. Messerschmidt, in an opinion to Dr. C. D. Waugh to the Wisconsin Board of Examiners in Optometry.

* * *

It is dangerous to hold a check too long after it has been given for service. Herbert H. Naujoks, assistant attorney general of Wisconsin, in an opinion to State Superintendent John Callahan, held that delay on the part of a holder of a bank check to present it for payment until the failure of the bank two weeks after its receipt, held negligence which will discharge the maker thereof to the extent that it has suffered from the delay.

That beef and hog liver contain more iron than calves' liver has been found as a result of studies in the home economics and agriculture chemistry laboratories at the University of Wisconsin.

Both hog and beef liver, though cheaper than the calves' liver, are usually less tender and less delicate in flavor than calves' liver. For the purpose of popularizing a cheap, iron-rich, but palatable food, studies are being made at the university.

Methods worked out at the university for improving the quality of hog and beef livers by cooking are described in a circular issued by the college of agriculture.

* * *

The construction has been started on one of the entrances to the medical exhibit in the Hall of Science of A Century of Progress for the Chicago's 1933 World's Fair. Rising from colored terraces and decorated in white, gray, red and gold, this 700 by 400 foot structure will be a masterpiece of modernist architectural design.

* * *

A total of 54 cases of infantile paralysis have been reported to the State Board of Health for the first six months of 1931. This is two times greater than the number of cases reported last year at this time, according to Dr. C. A. Harper.

» » » CORRESPONDENCE « « «

RACINE INVITES YOU

July 28, 1931.

To Mr. George Crownhart, Secretary,
Wisconsin State Medical Society,
Madison, Wisconsin.
Subject: Racine Community Health Day.
My dear Mr. Crownhart:

I am going to ask you to announce through the Wisconsin Medical Journal that on October 2, 1931, from 8:30 A. M. to 5:00 P. M. the Racine Board of Health, the Racine Association of Commerce and other Racine organizations interested in the public health are going to have open house at the new Health Department quarters in Racine's new city hall.

The present plans include a morning program devoted to registration and inspection trips to the filter plant, sewage interceptor project, health clinics, school health work, meat inspection, milk inspection and such other health projects in Racine as may interest visitors. In the afternoon we have planned a program to be held in the new Council Chambers featuring such speakers as the state health officer, the health commissioner of Milwaukee, the executive secretary of the Wisconsin Anti-Tuberculosis Association, the director of the Bureau of Nursing of the State Board of Health, the superintendent of Racine public schools and the secretary of the Racine Association of Commerce.

There will also be health exhibits by the State Board of Health, Wisconsin Anti-Tuberculosis Association, the Racine Health Department and other public health organizations in Racine.

We wish particularly to invite the presence of health officers, members of boards of health and mayors of Wisconsin cities to spend this day with us and see what Racine is doing for the health of its citizens.

Any announcement that you can give of this event in the Wisconsin Medical Journal will be greatly appreciated.

"Yours for Health",
W. W. BAUER, M. D.,
Commissioner of Health.

LIABILITY OF DRUGGIST

August 10, 1931.

Mr. J. G. Crownhart, Secretary,
Wisconsin State Medical Society,
Madison, Wis.
Dear Mr. Crownhart:

In a recent inquiry to this firm, you state the following circumstances:

> A physician, by mistake, prescribed an overdose of morphine for a patient. The druggist who filled the prescription, followed the directions of the physician.

You then inquire as to the liability of the physician and of the druggist for detrimental results to the patient as a result of the patient using such prescription.

Cases involving such circumstances rarely seem to reach the courts. There are apparently no Wisconsin cases directly in point and it becomes necessary to rely on such authority as can be found in other jurisdictions.

Liability of the physician. A physician is liable for his negligent acts in the treatment of his patients, and the writing of an erroneous prescription is considered, in the eyes of the law, as negligence per se. This principle would seem to govern the case you state of an "overdose" of so well a known drug as morphine, for an "overdose" is a form of an erroneous prescription.

Understand, of course, that the above statement of law does not refer to questions involving the physician's exercise of proper judgment, but to cases, as here, where he clearly makes a mistake. The physician is liable in such cases even though the druggist who compounded the prescription was also guilty of negligence and this liability has been held to extend even where the prescription was taken to a druggist other than the one to whom it was directed by the physician. See: *Murdock vs. Walker*, 43 Ill. A. 590, *Jeannotte vs. Corrilard*, 3 Que. Q. B. 461. See also: 48 C. J. 1133, sec. 126, notes 65–66.

Liability of the druggist. It should be noted at the outset that a druggist who fills a prescription in accordance with the directions contained therein is not necessarily negligent because the particular prescription happens to be an overdose. A druggist is required to exercise toward his patron only the degree of care known in the law as "ordinary." This is controlled in part by statutory regulations and in part by reference to the degree of vigilance and prudence commensurate with the dangers which may result from a druggist's act, here the compounding of a narcotic prescription. See: 19 C. J. 778–780, secs. 36, 37, 44, notes 41–47, 74–75.

In the case stated, if the overdose were so great that any person having a general knowledge of drugs would know that the quantity prescribed might well be injurious, or even fatal, in any case, it would be negligence for a druggist to fill such a prescription. But where the prescription called for amounts of morphine which, though an overdose in a particular instance, would not necessarily be so in all instances, the druggist would not be liable. Particular knowledge of what constitutes an overdose in a particular case is the special outlook of the physician and not of the druggist.

Conclusions:

1. *The writing of an erroneous prescription by a physician constitutes negligence for which the physician is primarily liable.*

2. *A druggist is liable for overdoses of drugs contained in prescriptions he fills, only where such overdoses are a result of his own negligence, or where, by virtue of his training, he must have known that the quantity of any drug contained therein would be an overdose in any instance.*

Under the brief statement which you gave us, we are unable to extend this inquiry further. In the event that this does not cover the exact points your physician has in mind, we should be glad to receive a fuller statement of the facts and endeavor to answer his questions as he desires.

Wisconsin Basic Science Examination Questions of June

DIAGNOSIS

Answer any *five* of the following.

1. Differentiate squamous eczema from scabies.
2. Differentiate furunculosis from carbuncles.
3. Differentiate by characteristic symptom Hodgkin's and Addison's disease.
4. Differentiate:
   - Acute nephritis.
   - Chronic parenchymatous nephritis.
   - Chronic interstitial nephritis.

   State only pathological changes and the urinary findings by tabulation.
5. Differentiate simple goitre from exophthalmic.
6. Differentiate myxedema from simple goitre.
7. Differentiate erythema simplex from urticaria.

PHYSIOLOGY

1. State the modern theory of renal secretion.
2. Define:
   - (a) Action current.
   - (b) Electrolytes.
   - (c) Osmotic pressure.
3. What is bile pigment and where is it formed?
4. Name the known functions of the liver.
5. How is respiratory activity regulated?
6. What is meant by basal metabolic rate and what value has it in medicine?
7. Sketch and label a normal electrocardiographic tracing and explain what the various waves indicate.
8. What are blood platelets and where are they formed and destroyed?

ANATOMY

Answer any *five* questions.

1. Describe the osteology of the pelvis.
2. Describe the origin and course of the principal nerves of the upper extremity and give the group muscle enervation of the upper extremity.
3. Discuss the anatomy of the peritoneum (by aid of diagrams or otherwise).
4. Discuss the anatomy of the male urethra and the prostate gland.

5. Describe the relationships and blood supply of the duodenum, gall bladder and bile duct.
6. Describe the knee joint.
7. Describe the structure of the lungs.

Answer any five questions.

PATHOLOGY

1. Define pathology.
2. Give the blood manifestations in:
   (a) Pernicious anemia
   (b) Lymphatic leukemia
   (c) Acute hemorrhage
   (d) Agranulocytosis
3. Differentiate granulomatous or hyperplastic inflammatory lesions from true neoplasms.
4. Discuss pulmonary embolism.
5. Define inflammation.
6. Discuss the relationship between hyperglycemia and glycosuria.
7. Discuss repair and regeneration of tissue.

Upwards of Nine Hundred to Attend the 90th Anniversary Meeting of the State Medical Society at Madison, Wednesday, Thursday, and Friday, September 9, 10 and 11

Final arrangements have been completed for an anticipated attendance of 900 members at the 90th anniversary meeting of the State Medical Society at Madison, September 9, 10 and 11. Every facility of the large Memorial Union building on the University of Wisconsin campus is to be devoted to the housing of this meeting during the three days of this general session.

With eighteen guest speakers and eighty-eight papers from within the state, scientific sessions will be held on both Wednesday and Thursday evenings, an innovation in state meeting programs. Following the custom of past years, two hours of each afternoon will be devoted to scientific sessions in three meeting rooms to provide the wide choice of program material that each member may select that which is of greatest interest to him in his actual practice. The mornings, evenings, and close of each afternoon will be devoted to scientific programs in the general assembly room of the Memorial Union building.

With time extended over that allotted a year ago, members will have a choice of attending any one of seven round table luncheons on Thursday noon, and the alumni luncheons will be held on Wednesday noon. Wednesday evening will be devoted to a buffet supper for the members to be followed by a smoker, and members and their wives will join for a supper on Thursday evening. A special program, announced in this issue, has been arranged for the wives, daughters, and mothers of members who are in attendance.

SYNOPSIS OF ANNUAL MEETING PROGRAM

TUESDAY

9:00 a. m.—Maple Bluff, practice play
12:00 noon —Maple Bluff, golf luncheon
12:00 noon —Council, Union building
1:00 p. m.—Golf tournament
7:00 p. m.—House of Delegates

WEDNESDAY

7:30 a. m.—Registration
8:00 a. m—First scientific session
10:15—10:30—Intermission
12:00 noon—Alumni luncheons
1:45 p. m.—Scientific sessions, 3 rooms
1:45 p. m.—Second session, House of Delegates
3:50—4:00—Intermission
4:00 p. m.—General assembly
5:45 p.m.—Members buffet supper-smoker
6:00 p. m.—Auxiliary, dinner for officers
7:30 p. m.—Evening scientific session

THURSDAY

7:30 a. m.—Registration
8:00 a. m.—Scientific session
10:15—10:30—Intermission
12:00 noon—Round table luncheons
12:00 noon—Auxiliary luncheon and meeting
2:15 p. m.—House of Delegates
2:15 p. m.—Scientific sessions, 3 rooms
3:55—4:05—Intermission
4:00—5:00—Auxiliary reception
4:05 p. m.—General assembly
5:30 p. m.—Supper for members and families
7:30 p. m.—Council awards
7:45 p. m.—Scientific sessions
7:45 p. m.—Auxiliary, bridge

FRIDAY

7:30 a. m.—Registration
8:00 a. m.—Scientific session
10:15—10:30—Intermission
12:00 noon—Luncheon service in Rathskellar
12:15 noon—Medical women, luncheon
1:45 p. m.—Scientific sessions, 3 rooms
3:10—3:20—Intermission
3:20 p. m.—General assembly

The final program as announced by Dr. Arthur G. Sullivan, chairman of the com-

mittee on scientific work, includes the following guest speakers:

GUEST SPEAKERS

1. DR. WILLIAM L. BENEDICT, Professor of Ophthalmology, Mayo Clinic, Rochester.
2. DR. HOWARD L. BEYE, Professor of Surgery, University of Iowa, Iowa City.
3. DR. JOSEPH C. BLOODGOOD, Clinical Professor of Surgery, Johns Hopkins University, Baltimore.
4. DR. WILLIAM F. BRAASCH, Professor of Urology, Mayo Clinic, Rochester.
5. DR. HERMAN C. BUMPUS, JR., Associate Professor of Urology, Mayo Clinic, Rochester.
6. DR. HARRY B. CULVER, Associate Professor of Urology, Northwestern University Medical School, Chicago.
7. DR. ARTHUR H. CURTIS, Professor of Obstetrics and Gynecology, Northwestern University Medical School, Chicago.
8. DR. H. EARLE CONWELL, Chief Orthopedist, Tennessee Coal, Iron and Railroad Company, Birmingham.
9. DR. GEORGE B. EUSTERMAN, Associate Professor of Medicine, Mayo Clinic, Rochester.
10. DR. SAMUEL J. FOGELSON, Department of Experimental Surgery, Northwestern University Medical School, Chicago.
11. DR. MELVIN S. HENDERSON, Professor of Orthopedic Surgery, Mayo Clinic, Rochester.
12. DR. DEAN LEWIS, Professor of Surgery, Johns Hopkins Medical School, Baltimore.
13. DR. JENNINGS C. LITZENBERG, Professor of Obstetrics and Gynecology, University of Minnesota Medical School, Minneapolis.
14. DR. ROY D. McCLURE, Surgeon In-Chief, Henry Ford Hospital, Detroit.
15. DR. HERMAN O. McPHEETERS, Attending Surgeon, Asbury Hospital, Fairview Hospital and Northwestern Hospital, Minneapolis.
16. DR. CHARLES W. MAYO, Consulting Surgeon, Mayo Clinic, Rochester.
17. DR. GORDON B. NEW, Professor of Oto-Laryngology and Rhinology, Mayo Clinic, Rochester.
18. DR. FRED W. RANKIN, Associate Professor of Surgery, Mayo Clinic, Rochester.

SPECIAL CANCER PROGRAM

Through the efforts of the Committee on Cancer, a special program has been arranged for physicians and allied groups during the three days of the meeting. On Wednesday noon, September 9th, Dr. Bloodgood will speak before the Federated Women's Club Luncheon at the Women's Building on "What Every Woman Should Know About Cancer". This address will be open to wives of the members, but request for reservation must be sent to Mr. Crownhart, Secretary of the Society.

Wednesday evening Dr. Bloodgood will address a large dental meeting on "Tumors of the Jaw." As announced in the program, Dr. Bloodgood's address for the profession will be on Thursday morning and a round table luncheon is devoted to the subject of organizing cancer clinics in general hospitals, on Thursday noon. From 9 to 11 Friday morning, Dr. Bloodgood will conduct a clinical pathological conference for pathologists and radiologists only, which will be devoted to a microscopic examination of tumors, discussion of clinical cases and final diagnosis. Tissue, difficult of diagnosis, may be submitted for this conference by forwarding tissue and clinical synopsis to Dr. W. D. Stovall, Madison, by September first. Sections will then be prepared and the case will be discussed.

The detailed scientific program follows:

TUESDAY, SEPTEMBER 8

9:00 A. M. Maple Bluff Golf Course open for Practice Play. Golf Chairman Dr. Albert R. Tormey, Madison, Wisconsin.

12:00 M. Golf Luncheon.

1:00 P. M. Golf Tournament — Maple Bluff Golf Club.

12:00 M. Council Meeting, Memorial Union.

7:00 P. M. House of Delegates, First Session, Memorial Union.

WEDNESDAY, SEPTEMBER 9

7:30 A. M. Registration—Memorial Union Building. Exhibits open.

8:00 A. M. Great Hall. Scientific Medical Motion Pictures With Sound, furnished by the Petrolagar Laboratories.

a) "Anatomy of The Female Pelvis and Perineum" by Doctors H. B. Kellogg and W. F. Windle of the Department of Anatomy, Northwestern University, Chicago—two reels—thirty-five minutes.

b) "Suspension Of The Uterus For Retro-Displacement" by Dr. H. O. Jones, associate professor of Gynecology, Northwestern University, Chicago—one reel—fifteen minutes.

c) "Sub-Total Abdominal Hysterectomy For Uterine Fibroids" by Dr. H. O. Jones, Northwestern University, Chicago—two reels—thirty-five minutes.

Memorial Union Building on University campus which will house September annual meeting.

9:25 A. M. Dr. Volney B. Hyslop, Madison, "Principles To Be Observed In The Treatment Of Congenital Harelip And Cleft Palate."

9:50 A. M. Dr. Robert Burns, Madison, "Osteomyelitis."

10:15 A. M. Intermission (See The Exhibits).

10:30 A. M. Dr. Hartwig M. Stang, Eau Claire, "Intravenous Urography; Its Place In Urology And General Practice."

10:55 A. M. Dr. Harry B. Culver, Chicago, Illinois, "Significance Of Renal Pain." *(Guest)*

11:20 A. M. Dr. Hermon C. Bumpus, Rochester, Minnesota, "Punch Prostatectomy." *(Guest)*

11:45 A. M. Dr. Joseph F. Smith, Wausau, "Report Of The A. M. A. House Of Delegates."

12:00 Noon Alumni Luncheon Meetings.

1:45 P. M. **OLD MADISON Dr. John P. Harkins, Madison, presiding.**

Dr. James K. Trumbo, Wausau, "Ocular Manifestations Of Focal Infections."

2:10 P. M. Dr. Edward S. Ryan, Sheboygan, "Conservative Treatment Of Nasal Infections."

2:35 P. M. Dr. Mark Nesbit, Madison, "The Eye And General Medicine."

3:00 P. M. Dr. Frederick A. Davis, Madison, "Experience With Avertin In Eye Cases."

3:25 P. M. Dr. Henry B. Hitz, Milwaukee, "Acute Mastoiditis."

1:45 P. M. **GREAT HALL Dr. William S. Middleton, Madison, presiding.**

Dr. John H. Karsten, Horicon, "The Small Town Physician In General Practice And His Relationship To The Medical Profession."

2:10 P. M. Dr. Robert C. Thackeray, Racine, "Determination Of Circulatory Fitness With A Flarimeter."

2:35 P. M. Dr. Charles M. Gleason, Manitowoc, "Relation Of The Life Insurance Examiner, To The Agent, The Company, And The Applicant."

3:00 P. M. Dr. Herman T. Schlegel, Wausau, "Treatment Of Asthma."

3:25 P. M. Dr. Hugh P. Greeley, Madison, "Multiple Sensitiveness In Hay Fever And Asthma."

GOLF TOURNAMENT

The annual golf tournament will be held at Maple Bluff Country Club on Tuesday, September 8th. Dr. Al Tormey, Madison, chairman of arrangements, announces that the course will be open from nine to twelve in the morning for practice play.

All will attend a buffet luncheon at twelve noon which will be followed by the opening of the tournament play at 1:00 p. m. Prizes will be awarded immediately following conclusion of the tournament play.

145 P. M. TRIPP COMMONS Dr. Walter G. Sexton, Marshfield, presiding.
Dr. Otto V. Pawlisch, Reedsburg, "Problems Of Arteriosclerosis In General Practice."

2:10 P. M. Dr. Roger C. Cantwell, Shawano, "Substernal Pain."

2:35 P. M. Dr. George V. Lynch, Oshkosh, "Pathological Conditions Of The Genitourinary Tract That Require Transplanting The Ureters Into The Sigmoid."

3:00 P. M. Dr. Francis B. McMahon, Milwaukee, "Treatment Of Cancer Of The Mouth." (Slides)

3:25 P. M. Dr. Arthur V. DeNeveu, Milwaukee, "Skull Fractures And Treatment; A Review Of 600 Cases."

3:50 P. M. Intermission (See The Exhibits).

4:00 P. M. General Session. Great Hall.
President's Address—Dr. C. A. Harper, Madison.

4:25 P. M. Dr. W. L. Benedict, Rochester, Minnesota, "Infection Of The Pelvic Organs Of The Female In Relationship To Diseases Of The Eye." *(Guest)*

4:50 P. M. Dr. Melvin S. Henderson, Rochester, Minnesota, "Fractures Of The Ankle Joint, (Pott's)." *(Guest)*

5:45 P. M. Members' Buffet Supper. Tripp Commons.

7:30 P. M. Evening Session. Great Hall.
Dr. John W. Powers, Milwaukee, "Evaluation Of The Various Treatments For Ununited Fractures Of The Hip."

7:55 P. M. Dr. William F. Braasch, Rochester, Minnesota, "Urology And The General Practitioner." *(Guest)*

8:20 P. M. Dr. Gordon B. New, Rochester, Minnesota, "The Developments In The Treatment Of Deformities Of The Face And Neck." (Slides) *(Guest)*

8:45 P. M. Dr. John O. Dieterle, Milwaukee, "Some Observations In The Diagnosis And Treatment Of Gas Gangrene Complicating Compound Fractures."

THURSDAY, SEPTEMBER 10

8:00 A. M. Great Hall. Dr. Joseph C. Bloodgood, Baltimore, Maryland, "What Every Doctor Should Know About Pathology." *(Guest)*

9:00 A. M. Dr. James B. Vedder, Marshfield, "External Cephalic Version." (Motion Picture)

9:25 A. M. Dr. Andrew J. Weber, Milwaukee, "Arthritis Of The Spine With Reference To Industrial Accidents."

9:50 A. M. Dr. Reginald H. Jackson, Madison, "Spinal Anesthesia—Resume Of Observations Based On 3,000 Inductions. Cinematography Film To Demonstrate Technique And Advantages Conferred On The Patient And Surgeon, By This Method."

10:15 A. M. Intermission (See The Exhibits).

10:30 A. M. Dr. Mynie G. Peterman, Milwaukee, "The Treatment Of Epilepsy In Children."

10:55 A. M. Dr. Roy D. McClure, Detroit, Michigan, "The Results Of The Use Of Iodine Salt In Detroit As Noted In The Effect Upon The Demand For Surgery." *(Guest)*

11:20 A. M. Dr. Eugene S. Sullivan, Madison, "The Surgical Problem Of Pelvic Endometriosis."

11:45 A. M. Dr. W. E. Bannen, LaCrosse, "Report On Sections And Section Work Of The A. M. A. Meeting."

12:00 NOON–2:15 P. M. ROUND TABLE LUNCHEONS.

1 OLD MADISON – A. Dr. Louis R. Head, Madison, presiding.
Dr. John W. Harris, Madison, "Problems In Obstetrics a) Induction Of Labor, b) Occiput Posterior, c) Breech."
General Discussion.

2 OLD MADISON – B. Dr. Joseph W. Gale, Madison, presiding.
Dr. Erwin R. Schmidt, Madison, "Problems In Surgery a) Cancer Of Breast, b) Cancer Of Uterus."
General Discussion.

3 POPOVER Dr. Elmer L. Sevringhaus, Madison, presiding.
Dr. Ray C. Blankinship, Madison, "Problems In Medicine a) Cardiac Decompensation, b) Bronchopneumonia."
General Discussion.

4 ROUND TABLE ROOM Dr. Walter H. Sheldon, Madison, presiding.
Dr. Robert Burns, Madison, "Problems In Fractures a) Pott's Fracture, b) Fracture Of The Os Calcis."
General Discussion.

A portion of the main meeting room.

5 **LEX VOBISCUM Dr. Frank L. Weston, Madison, presiding.**
Dr. H. Curtis Johnson, Madison, "Problems In Pediatrics a) Nephritis, b) Rickets, c) Anorexia."
General Discussion.

6 **BEEF EATER'S Dr. John P. Harkins, Madison, presiding.**
Dr. E. E. Neff, Madison, "Problems In Nose, Throat And Ear Surgery."
General Discussion.

7 **ROUND TABLE LOUNGE Dr. W. D. Stovall, Madison, presiding.**
Dr. Bowman C. Crowell, Chicago, Registrar Committee on Bone Sarcoma, A. C. of S., "Organization Of Cancer Clinics in General Hospitals."

2:15 P. M. **OLD MADISON Dr. William S. Middleton, Madison, presiding.**
Dr. John C. Doolittle, Lancaster, "Some Lessons Learned From Our Mistakes."

2:40 P. M. Dr. Arthur E. McMahon, Glenwood City, "Obstetrical Anesthesia And Analgesia In General Practice."

3:05 P. M. Dr. Francis E. Butler, Menomonie, "Two Years' Experience With Spinal Anesthesia."

3:30 P. M. Dr. Ralph M. Waters, Madison, "Clinical Aspects Of Anoxemia."

2:15 P. M. **GREAT HALL Dr. Walter G. Sexton, Marshfield, presiding.**
Dr. W. G. Riopelle, Beaver Dam, "Medical Economics."

2:40 P. M. Dr. Albert A. Axley, Washburn, "The Small Community Hospital."

3:05 P. M. Dr. Harold M. Coon, Stevens Point, "Positive Factors In The Diagnosis Of Pulmonary Tuberculosis."

3:30 P. M. Dr. John L. Garvey, Milwaukee, "Spontaneous Subarachnoid Hemorrhage And The Clinical Significance Of Blood In The Spinal Fluid."

2:15 P. M. **TRIPP COMMONS Dr. Eugene S. Sullivan, Madison, presiding.**
Dr. Leslie W. Tasche, Sheboygan, "Carcinoma Of The Oesophagus."

The bar in the Rathskellar.

2:40 P. M. Dr. Clarence B. Hatleberg, Chippewa Falls, "Diagnosis And Treatment Of Ectopic Pregnancy."

3:05 P. M. Dr. Robert L. MacCornack, Whitehall, "Embolism And Thrombosis Of The Superior and Inferior Mesenteric Vessels."

3:30 P. M. Dr. Guy R. Duer, Marinette, "Practical Problems In The Practice Of Medicine."

3:55 P. M. Intermission (See The Exhibits).

4:05 P. M. **General Session. Great Hall.**
Dr. Arthur H. Curtis, Chicago, Illinois, "Stricture Of The Uterine Cervix, Its Etiology, Clinical Characteristics, And Complications; — Treatment." *(Guest)*

4:30 P. M. Dr. Archie A. Skemp, LaCrosse, "The General Practitioner's Response To The Challenge Of Obstetrics."

4:55 P. M. President-Elect's Address — Dr. Otho Fiedler, Sheboygan.

5:30 P. M. **Supper for members and families. Tripp Commons.**

7:30 P. M. **Evening Session. Great Hall.**
Honorary Awards By The Council.

7:45 P. M. Dr. Justin D. Leahy, Park Falls, "Injuries Of The Back."

8:10 P. M. Dr. H. Earle Conwell, Birmingham, Alabama, "Fractures Of The Spinal Vertebrae Without Cord Injury." (Lantern Slides, A Report Of 100 cases.) *(Guest)*

8:35 P. M. Dr. Ernest W. Miller, Milwaukee, "Electric Burns."

9:00 P. M. Dr. John M. Dodd, Ashland, "Idealism In The Practice Of Medicine."

FRIDAY, SEPTEMBER 11

8:00 A. M. Great Hall. Dr. Dean Lewis, Baltimore, Maryland, "Aneurysms, Congenital And Traumatic." *(Slides) (Guest)*

9:00 A. M. Dr. Ralph M. Carter, Green Bay, "Skeletal Traction In Fractures Of The Lower Extremities." (Slides)

9:25 A. M. Dr. Roy P. Potter, Marshfield, "Roentgenological Findings In Non-Tuberculous Lesions Of The Hip." (Lantern Slides)

9:50 A. M. Dr. Joseph Dean, Madison, "Appendicitis."

10:15 A. M. Intermission (See The Exhibits).

10:30 A. M. Dr. Herman O. McPheeters, Minneapolis, Minnesota, "The Mechanics Of The Reverse Flow Of Blood In Varicose Veins And Its Clinical Application To The Injection Treatment." (Slides) *(Guest)*

10:55 A. M. Dr. Samuel J. Fogelson, Chicago, Illinois, "The Present Status Of The Mucin Treatment In Peptic Ulcer." *(Guest)*

11:20 A. M. Dr. Karl W. Doege, Marshfield, "What I Think About Cancer."

11:45 A. M. Dr. J. Gurney Taylor, Milwaukee, "Report On The Scientific Exhibits At The A. M. A. Meeting."

12:00 M. Medical Women—Luncheon. Beefeater's Room.

1:30 P. M. **GREAT HALL Dr. Walter G. Sexton, Marshfield, presiding.**
Dr. Julius F. Mauermann, Monroe, "Catarrhal Enteritis Simulating Pelvic Disease In Women."

1:55 P. M. Dr. Edwin F. Schneiders, Madison, "The Early Recognition, And Adequate Treatment Of Pre-Cancerous Lesions Of The Cervix." (Slides)

2:20 P. M. Dr. Gunnar Gundersen, LaCrosse, (and Dr. R. B. Johnson) "Observations Of Duodenal Obstruction."

2:45 P. M. Dr. Carl S. Williamson, Green Bay, "Surgical Indications In Peptic Ulcers."

1:30 P. M. **OLD MADISON Dr. Ray C. Blankinship, Madison, presiding.**
Dr. Joe N. Sisk, Madison, "Cholecystography."

1:55 P. M. Dr. Lawrence V. Littig, Madison, "Cholecystography." (Joint Paper With Movie)

2:20 P. M. Dr. Nels Werner and Dr. Garner T. Scullard, Eau Claire, "Evaluation Of The Schilling Blood Count In Diagnosis."

2:45 P. M. Dr. Karl H. Doege, Marshfield, "Cardiac Irregularities."

1:30 P. M. **TRIPP COMMONS Dr. William S. Middleton, Madison, presiding.**
Dr. Harold R. Fehland, Wausau, "The Anemias Of Adolescence." (Slides)

The Rathskellar where the buffet supper-smoker will be held.

1:55 P. M. Dr. Edward H. Spiegelberg, Boscobel, "Congenital Pyloric Stenosis."

2:20 P. M. Dr. Everett L. Mason, Eau Claire, "Purpura Hemorrhagica."

2:45 P. M. Dr. Henry A. Sincock, Superior, "The Clinical Signs, Symptoms And Treatment Of Calcium Deficiency In Pregnancy, And Its Influence Upon The Child."

3:10 P. M. Intermission (See The Exhibits).

3:20 P. M. General Session. Great Hall.
Dr. Jennings C. Litzenberg, Minneapolis, Minnesota, "The Delivery Of Occiput Posterior." *(Guest)*

3:45 P. M. Dr. Howard L. Beye, Iowa City, Iowa, "Transphrenic Infection." *(Guest)*

4:10 P. M. Dr. Fred W. Rankin, Rochester, Minnesota, "Encouragements In The Surgical Treatment of Cancer Of The Colon And Rectum." *(Guest)*

4:35 P. M. Dr. George B. Eusterman, Rochester, Minnesota, "Observations On Carcinomatous Gastric Lesions Masquerading As Benign Ulcer." *(Guest)*

5:00 P. M. Dr. Charles W. Mayo, Rochester, Minnesota, "Pharyngo-Esophageal Diverticulum." *(Guest)*

Entertainment Program Announced for the Ladies

Under the auspices of the Auxiliary, wives, mothers and daughters of members will have a full program of entertainment on Wednesday and Thursday.

A reception in honor of the officers of the Auxiliary is to be held at the Executive Mansion, 130 East Gilman Street, from four to five, Wednesday afternoon, September ninth. The reception at the Governor's Mansion will be informal.

Officers of the State Auxiliary will have a dinner meeting at the Loraine Hotel on Wednesday evening, at which time they will act as an executive committee in discussing the problem of a state organization.

On Thursday noon all are to attend the Auxiliary luncheon at the Memorial Union building at which Mrs. James Blake, first vice-president of the National Auxiliary is to be the guest speaker. Following the addresses of Mrs. Blake and Mrs. C. R. Bardeen, Madison, president, elections for the ensuing year will be held.

Following the Thursday afternoon program, ladies will attend the supper for members and their families. Following the dinner they will attend the evening session to witness the presentation of the Council awards. At the conclusion of this brief ceremony, the Auxiliary will again be hosts at at bridge party in the building which will be concurrent with the evening scientific session.

House of Delegates to Meet Tuesday Evening September 8th

Members of the House of Delegates will hold their first meeting in Great Hall of the Memorial Union building at seven, Tuesday evening, September 8th. At this session all committee reports will be referred to reference committees, resolutions will be received, and elections will follow for Councilors to succeed Doctors C. A. Harper, Madison, third district; Wilson Cunningham, Platteville, fourth district; A. H. Heidner, West Bend, fifth district; and F. Gregory Connell, Oshkosh, sixth district.

A delegate to the American Medical Association will also be chosen to succeed Dr. Joseph F. Smith, Wausau, and an alternate delegate to succeed Dr. M. D. Bird, Marinette. The elections for the offices of President-Elect, Speaker of the House and Vice-Speaker of the House will be referred to a nominating committee consisting of one representative from each of the twelve councilor districts. This nominating committee will also be selected at the Tuesday evening session and will report at the Thursday afternoon session at which time elections will be held. All committee reports and recommendations which will come before the House for action will be found in the August issue of the Journal, with the exception of that of the Editorial Board which is printed herewith.

REPORT OF EDITORIAL BOARD

To The 1931 House of Delegates:

During the past year the routine work of the Journal has been carried on as usual. The same division of responsibilities has continued as in previous years; namely, Dr. Dearholt has been in charge of the Editorial Section, and Doctors Smith and Lotz in charge of the Original Articles Section. Dr. H. B. Podlasky, representing the Radiological Society, has been very helpful in the selection and editing of the papers for the Radiological Section of the Journal.

The only change of note in the management of the Journal has been the addition of a part-time medical assistant to the Editorial Board.

You may recall that two years ago and again at the last annual meeting your Editorial Board presented to the Council a request for a discussion and possible solution of the question of the Medical Editorship of the Journal. After freely discussing the matter at both meetings, the Council decided, and we believe wisely so, that the financial condition of the Society did not at that time warrant the additional expense of a full-time or part-time medical editor.

At the last meeting of the Council—January, 1931—the question again came up for discussion, and resulted in a grant of $2500.00 to the Editorial Board, the money to be used to help make our present Journal a better journal and of greater value to the Members of our Society.

After consideration of various possibilities, your Board decided upon the employment of a physician as medical editor and as assistant to the Board. This action is in no way to be interpreted to mean that your Editorial Board is going to relinquish the responsibilities and duties of the Journal on to the shoulders of one individual. We would all object to such a policy, but we do feel that while the responsibilities of your publication should remain in the hands of voluntary members, some of the duties may well be transferred to a paid assistant.

It is with pride and pleasure and considerable gratification that we announce the appointment of Dr. John Huston of Milwaukee to this position. Dr. Huston is a graduate of the University of Wisconsin and of the Harvard Medical School, and we believe will bring to the Journal the interest and enthusiasm so necessary to keep our publication in the front rank of state journals.

Respectfully submitted,
J. F. Smith, M. D.
H. E. Dearholt, M. D.
Oscar Lotz, M. D.

Sixteen Exhibits to be Presented at Meeting

Sixteen exhibits will fill the main floor hall of the Memorial Union building with their technical exhibits during the three days of the 90th anniversary meeting. In addition to these technical exhibits, a special exhibit will also be presented by the Medical Library Service, and in a separate hall the Canti cancer film will be run continuously during the three-day session.

Exhibits at the meeting will include:

Booth No.	*Exhibitor*
1	Roemer Drug Company
2	Mead Johnson & Company
3	Petrolagar Laboratories
4	E. H. Karrer Company
5	Hanovia Chemical & Mfg. Co.
6	Victor Mueller Company
7	Kremers–Urban Company
8	V. H. Hurley Company
9	Morris F. Fox Company
10	Scanlan–Morris Company
11	E. R. Squibb & Sons Co.
12	Horlick's Malted Milk Corp.
13	General Electric X-Ray Corp.
14	Medical Protective Company
15	Mellin's Food Company
16	W. B. Saunders Company

Memorial hall in the Union building.

High School Athletic Benefit Plan of W. I. A. A. Explained; Medical Fee Schedule Prepared

By P. F. NEVERMAN, Executive Secretary
Wisconsin Interscholastic Athletic Association
Marinette

The courts have held that educational institutions have no liability for injuries sustained by students. The same courts have held that schools promoting a program of physical education including athletics have no legal responsibility towards meeting financial obligations of boys who may be injured. The courts, in numerous decisions, have stated that Boards of Education, which pay the medical expense of boys injured in athletics, do so contrary to law and that the individual Board members approving a payment of this kind may be held personally liable for such payments.

The Board of Control of the Wisconsin Interscholastic Athletic Association two years ago began to devise a plan under which the actual medical expense incurred by boys as the result of athletic competition could be paid. The Board was assisted in this study by an insurance expert and by members of the State Insurance Commission. It was found that no statistics were available on athletic injuries; that few companies wrote policies covering athletic injuries and that in each case the rates were prohibitive for high school boys; that an insurance company would have to be incorporated if the W. I. A. A. were to undertake a regular plan of insurance and that the field was so extensive and the information so meagre that any plan should be limited until such time as complete figures were available. The Board of Control of the Wisconsin Interscholastic Athletic

Association felt that the protection of boys injured in athletics offered a real opportunity for service and decided to undertake the development of a plan to protect competitors. The organization of an insurance company with its attendant expense was discarded in favor of a benefit plan which could be administered by the already existing and functioning organization. The Board decided to finance the operation of the plan the first year out of its accumulated surplus. In other words, the cost of operation as well as the benefit payments during the first year were to be made from the surplus fund.

The following schedule of benefits was approved on July 15, 1930, and was in operation during the past school year:

Entire sight of one eye, if irrevocably lost	$200.00
Both arms broken above the elbows	150.00
Both legs broken above the knees	150.00
Both bones of either arm broken between wrist and elbow	100.00
Both bones of either leg broken between ankle and knee	100.00
Either leg broken above knee	100.00
Either arm broken above elbow	75.00
Either bone of either leg broken between ankle and knee	50.00
Either bone of either arm broken between wrist and elbow	50.00
Collar bone broken	40.00

A total of $5,330.00 was paid to high school boys during the 1930–31 school year. The injuries were divided as follows:

Broken collar bones	47
Broken legs	26
Broken arms	27

Besides the above, 186 other injuries not on the first year schedule were reported. These ranked from broken teeth, which number 21, to ruptured kidneys, which totaled 3. Eleven scheduled injuries were also reported which were not paid because the principal did not comply with the simple requirements for participation. More than 20,000 boys were protected and 93% of all Wisconsin high schools participated.

It was found during the year that in order to continue the plan the schools must meet part of the expense of the plan as the ordinary income of the W. I. A. A. could not carry the entire load. The schools, by referendum, approved an increase in their dues for the coming year of about $4,000.00 or sufficient to continue the plan for 1931–32.

NEW SCHEDULE

The schedule of benefits for the coming year was also revised both as to amount and injuries covered. The following is the schedule which has been approved for 1931–32:

Entire sight of one eye, if irrevocably lost	$200.00
Both arms broken above the elbows	150.00
Both legs broken above the knees	150.00
Both bones of either leg broken between ankle and knee	100.00
Both bones of either arm broken between wrist and elbow	75.00
Either leg broken above the knee	75.00
Either arm broken above the elbow	50.00
Either bone of either leg broken between ankle and knee	40.00
Either bone of either arm broken between wrist and elbow	35.00
Collar bone	30.00
Broken nose	10.00
Broken tooth	10.00
Broken bone in hand	7.50
Broken bone in foot	7.50

Note—Benefits on green stick fractures to be half of those listed in schedule.

Note—Radiograph may be required on all injuries scheduled at $35.00 or more. If x-ray is required on other scheduled injuries an allowance of $2.00 for each picture will be made in addition to scheduled benefit.

The requirements for participation include the thorough examination of the boys and the filing of a statement signed by the physician attesting to physical fitness. The same card requires the signature of parent or guardian giving permission to compete. The sports approved by physician and parent are indicated. All competition under the auspices of the school—intra-mural, interclass, and inter-school—both practice and contest is covered. After injury the principal files a preliminary report card. Upon receipt of this card three blanks are mailed to the principal. The blanks are to be signed by the boy, the principal and the physician. The medical director of the Board, Dr. M. D. Bird of Marinette, may require a radiograph if he deems this necessary. Checks are payable to the principal as the agent of the boy.

The plan as devised will protect the boys and will at the same time guarantee some remuneration to the physicians. During the past year charges for collar bones ranged from $10.00 to $90.00. Broken arms brought statements as low as $15.00 and as high as $150.00. Broken legs cost from $20.00 to $250.00.

The W. I. A. A. is asking the physicians of the state, members of the State Medical Society, to cooperate in the development of a complete coverage for boys injured in athletic competition. The 1931–32 schedule of payments has been given. Physicians are urged not to exceed this schedule. If the schedule is either high or low advise Sec'y J. G. Crownhart, 119 E. Washington Avenue, Madison, of this fact. The W. I. A. A. schedule represents the opinion of numerous physicians as to what the average cost of the listed injuries has been. Much of this work has been previously done by physicians out of a spirit of loyalty to the schools and this is, in a manner, a guarantee to the physicians of some compensation for their services. The schools will not be responsible for any amount in excess of their schedule. Lesser charges will be appreciated as the Association may not be able to continue as high a schedule of coverage on 20,000 boys.

We appreciate the service and cooperation of the physicians in the past and solicit it for the years ahead.

Contributions to Beaumont Memorial Reach Amount Needed as Memorial is Dedicated on August 30th

Contributions to the Beaumont Memorial, now standing on State Trunk Highway 18 in Prairie du Chien, reached the necessary figure of $700 as the Memorial was dedicated on Sunday, August 30th. The large granite boulder, nine feet in length and five feet high, with its plaque of bronze culminates the forceful plea of Dr. William Snow Miller before the State Medical Society just a year ago. The inscription on the boulder is printed on this page. The addresses at the dedication will be printed in full in the next issue of the Journal.

WILLIAM BEAUMONT, M. D., PIONEER IN PHYSIOLOGY

Born Lebanon, Conn., 1785
Died St. Louis, Mo., 1853

At Old Fort Crawford, One Mile And A Half Northwest Of This Spot, One Hundred Years Ago, Doctor Beaumont, A Surgeon In The United States Army, Performed Those Experiments on Alexis St. Martin Which Laid The Foundation For Our Knowledge of Digestion.

In Honor of His Pioneer Work This Memorial Has Been Erected by the State Medical Society of Wisconsin 1931

PROGRAM AT DEDICATION OF BEAUMONT MEMORIAL

At the site of the Second Hospital, State Trunk Highway 18. Prairie du Chien, 3 P. M., Sunday, August 30th

Presentation of the ground to the State Medical Society of Wisconsin by the Daughters of the American Revolution, Mrs. Goodsell Billings, Prairie du Chien, Regent of the D. A. R.

Acceptance for the State Medical Society of Wisconsin, Dr. C. A. Harper, Madison, President.

"Old Prairie du Chien," Dr. Peter L. Scanlan, Prairie du Chien, Member of the Beaumont Memorial Committee.

"Beaumont, The Man," Dr. William Snow Miller, Emeritus Professor of Anatomy, University of Wisconsin.

"Beaumont, The Physiologist," Dr. W. J. Meek, Professor of Physiology, University of Wisconsin.

Dedication, Dr. C. A. Harper, President of the State Medical Society of Wisconsin.

Acceptance for the City of Prairie du Chien, Mayor Francis J. Antoine, M.D.

The complete list of those members whose contributions made possible the memorial follow:

Algoma:
Foshion, H. V.
Antigo:
Wright, J. C.
Ashland:
Dodd Clinic
Prentice, J. W.
Bloomington:
Baldwin, F. H.
McLaughlin, H. J.
Blue Mounds:
Bancroft, H. V.
Brandon:
Shaykett, F. E.
Shepard, E. L.
Columbus:
Schmeling, A. F.
Cross Plains:
Froggatt, W. E. L.
Denmark:
Vosburgh, W. H.
Dorchester:
Foley, F. P.
Durand:
Schulberg, P. A.
Eau Claire:
Mitchell, R. E.

The Beaumont Memorial in place with ruins of old Fort Crawford in the background.

Eden:
Hardgrove, J. H.

Elkhorn:
Herzog, J. V.

Fond du Lac:
Borsack, K. K.
Boyd, G. T.
Dana, A. C.
Devine, H. A.
Devine, J.
Finn, W. C.
Florin, A. C.
Folsom, W. H.
Gardner, L. C.
Gavin, S. E.
Helz, J. W.
Howe, H. W.
Kosanke, F. E.
Layton, O. M.
Waldschmidt, W. J.
Wier, J.
Wojta, W. C.
Leonard, C. W.
Longley, J. R.
McCabe, P. G.
Meiklejohn, D. V.
Mills, R. G.
Pullen, A. J.
Rehorst, J. J.
Sharpe, H. R.
Sharpe, J. J.
Simon, L. J.
Smith, E. V.
Twohig, D.
Twohig, E.
Twohig, H. E.
Walters, D. N.
Wiley, F. S.
Yockey, J. C.

Green Bay:
Kelly, Webber

Kewaunee:
Wochos, W. M.

Kiel:
Nauth, D. F.

La Crosse:
Bannen, W. E.
Evans, Edward
Evans, James A.
Gundersen, Gunnar
Henke, W. A.
MacArthur, D. S.
McGarty, M. A.

Madison:
Bardeen, C. R.
Bunting, C. H.
Crownhart, J. G.
Davis, F. A.
Ewell, G. H.
Fox, Philip R.
Ganser, Wm. J.
Harkins, John P.
Harper, C. A.
Head, Louis R.
Jackson, Reginald H.
Middleton, Wm. S.
Miller, Wm. Snow
Schmidt, Erwin R.
Sullivan, Arthur G.
Sullivan, Eugene S.
Waters, R. M.

Maiden Rock:
Hogan, John

Manitowoc:
Gleason, C. M.
Rees, T. H.
Steckbauer, J. W.
Turgasen, F. E.

Marinette:
Axtell, Luella E.
Redelings, T. J.

Menasha:
Forkin, G. E.

Menomonie:
Butler, F. E.
Heising, A. F.

Milwaukee:
Baum, E. L.
Beckman, Harry
Blumenthal, R. W.
Boerner, R. W.
Brown, G. V. I.
Carson, W. J.
Cron, R. S.
Davis, Carl Henry
Dearholt, H. E.
Dieterle, J. O.
Eberbach, Carl W.
Egan, W. J.
Eisenberg, J. J.
Elconin, D. V.
Evans, C. A.
Everts, Edwin L.
Federspiel, M. N.
Fellman, G. H.
Fletcher, E. A.
Foerster, O. H.
Gaenslen, F. J.
Gordon, John S.
Gramling, Henry
Gramling, J. J.
Hipke, G. A.
Hitz, H. B.
Holbrook, A. T.
Jurss, C. D.
Jurss, G. J.
Koch, M. J.
Kristjanson, H. T.
Krzysko, Stanley
Ladewig, A. W.
LeCron, W. L.
Leitch, G. W.
Lotz, Oscar
Lynch, D. W.
Madison, F. W.
Madison, J. D.

(Continued on page 774)

PRESS SERVICE OF STATE MEDICAL SOCIETY

No serum does so much for public health as printer's ink

POISON IVY

Madison, Wis., July 22—The season of poison ivy, one of the commonest and worst of nature's abounding plant life, is now confronting Wisconsin vacationers, and demanding recognition as a cause of distressing poisoning leading to great discomfort and sometimes actual danger. This forms a subject treated this week by the Health Committee of the State Medical Society.

"Ivy is easily mistaken for other similar plants but has distinctive characteristics, and the inexperienced person should learn to recognize it," declares the bulletin of the State Medical Society issued today. "In Wisconsin it usually assumes the form of a low, erect plant, whose rootlets trail underground, and sometimes takes the nature of a vine, running over stones or having the tendency to climb the trunks of trees. In other climates than Wisconsin it may grow as a shrub, and it is often known as poison oak. It is often mistaken for woodbine, but woodbine has five leaves while ivy has but three, two of which are opposite and short stalked while the third or terminal leaflet is long stalked.

"Poison ivy leaves are shiny or wax-like, except in the early spring, while woodbine leaves are dull. The berries of the woodbine quickly turn to a deep blue; the ivy berries are smooth and greenish which change later to a yellowish white or ivory color. These berries remain on the plant until late in the season, and at first are globular, but later have a tendency to dry or wrinkle.

"In climates where the Virginia creeper is native, there is something of similarity between the two plants, although the former has from three to five leaflets. Poison ivy is found in fields, especially in shady places about the borders, in woodlands, along roadways, and upon the banks of streams and lakes. It occurs in city parks, mixed with other shrubbery, in such a way as to often escape observation.

"Another plant of a closely related family and giving rise to a similar poisoning is the poison sumac. The poison sumac grows in moist ground, usually in swamps or along the banks of streams and ponds, and is variously known as poisonous dogwood, poison elder, and poison ash. It frequently grows 10 or 20 feet in height, and very closely resembles our common sumac. It does not, however, bear the red fruit of the common sumac, but early in the summer yellowish green flowers appear in narrow clusters near the end of the branches, followed by shining ivory white or yellowish fruit.

"Poisoning usually occurs as a result of contact with some part of these plants. Some people seem to be more easily poisoned than others. The poisoning makes its appearance by reddening of the skin, having the appearance of an eczema, usually with a multitude of minute blisters upon the inflamed surface. There is a great swelling in the pronounced case. The eruption is almost always upon exposed parts of the body first.

"One of the surest and best ways to prevent the eruption is the use of soap and hot water, for the poison requires some time to penetrate the skin. A heavy lather should be used with a continuous washing for about five minutes. The water should be changed frequently, and the lather or water should not touch the unexposed areas of the skin. Repeat the process in four or five hours. Alcohol diluted about one-half is also of value in washing exposed skin. A bad case always requires the attention of a physician."

VALUE OF FRUIT

Madison, Wis., July 29—"Eat more fruit during the summer months" is the motto which the Educational Committee of the State Medical Society declared in a statement today should be hung on the walls of every dining room in Wisconsin. Fresh fruits, because of their large content of water, are cooling, refreshing and appetizing. Fruits are a class of foods which help to ward off diseases.

"Some people look on fruit as a luxury, but there are very good reasons why we should eat fruit daily," declares the health bulletin. "All fruits contain certain salts of organic acids which have a more or less stimulating action on the kidneys, and some of them such as pears, figs, and prunes have a laxative effect. In addition to this, fruit furnishes a certain indigestible bulk or roughage which tends to retain water in the intestines and thus helps to regulate the functional movements.

"Children's physicians recommend that all babies of the age of six months should be given small amounts of mild fruit juice or tomato juice daily. This is particularly necessary in the case of infants fed on cow's milk or other prepared milk foods. Unless one of these juices is given, a disease known as scurvy may develop. The mild form of this disease often passes unrecognized for a time, being noted only in a slowing up of the growth of the child later on.

"Fruit is one of the so-called 'protective foods,' and should be used in some form daily. Fresh fruits, because of their large content of water, are always cooling, refreshing and appetizing. Fruit which is not thoroughly ripe, or is decomposed should not be eaten.

"Bananas are a staple fresh fruit, high in fuel value, low in price and easy to prepare. Digestive difficulties usually arise from eating them too green, too fast, or from eating too many. They are most digestible when fully ripe (that is when the skins have darkened, and the fruit is soft and yet firm). They are usually cheaper this way, because the merchant knows they will not keep long afterwards. Bananas baked or stewed and mashed, flavored with lemon and sugar are very palatable. Unripe bananas baked in the skin may take the place of a vegetable in a meal.

"Next to bananas, apples are our most abundant market fruit. Their many and varied uses are too well known to require comment.

"When we chew fibrous food, such as raw fruit, it is said that we exert a pressure of from 100 to 150 pounds on the teeth. This aids in good circulation of blood, and in children undoubtedly develops teeth and jaws. Raw fruit also leaves the teeth freer from adhering matter than do soft foods. Hence it is wise to end a meal with raw fruit, since it not only acts as a cleanser of the teeth, but it also helps to preserve them by stimulating the secretion of a strongly alkaline saliva which coats the teeth and counteracts the effect of particles of food which would otherwise remain."

(Continued on page 772)

THE JOURNAL BOOK SHELF

The Doctor and His Investments. By Merryle S. Rukeyser, B.Lit., M.A., financial editor, Medical Economics and Dental Survey; financial and editorial writer, New York American and associated newspapers; associate in journalism, Columbia University; author, "Financial Advice to a Young Man," "The Common Sense of Money and Investments," and "Investment and Speculation." Price $2.50. P. Blakiston's Son & Co., Inc., 1012 Walnut St., Philadelphia, Pa.

An Introduction to Gynecology. By C. Jeff Miller, M.D., professor of gynecology, Tulane University School of Medicine; chief of the department of gynecology of Touro Infirmary; senior visiting surgeon, Charity Hospital, New Orleans. Illustrated. Price $5.00. C. V. Mosby Co., St. Louis, 1931.

Clinical Dietetics. A textbook for physicians, students, and dietitians. By Harry Gauss, M.S., M.D., F.A.C.P., instructor in medicine, University of Colorado, School of Medicine. Assisted by E. V. Gauss, B.A., formerly assistant dietitian, Presbyterian Hospital, Denver. Illustrated. Price $8.00. C. V. Mosby Co., St. Louis. 1931.

Textbook of Histology. For medical and dental students. By Eugene C. Piette, M. D., pathologist and director of the Laboratory of the West Suburban Hospital, Oak Park, Illinois. Consultant pathologist of the Chicago State Hospital, Chicago. With 277 illustrations, some in color. Price $4.50 net. F. A. Davis Company, Philadelphia, 1931.

BOOKS RECEIVED FOR REVIEW

Cutaneous X-Ray And Radium Therapy. By Henry H. Hazen, A.M., M.D. Professor of dermatology, medical department of Georgetown University; professor of dermatology, Medical Department of Howard University; Member of American Dermatological Association, American Roentgen Ray Society. Illustrated. Price $3.00. C. V. Mosby Co., St. Louis, Mo. 1931.

Modern Proctology. By Marion C. Pruitt, M. D., L.R.C.P., S.(Ed.), F.R.C.S.(Ed.), F.A.C.S., Atlanta, Ga. Associate in surgery, Emory University School of Medicine; assistant visiting surgeon, Grady Hospital; Procotologist, Crawford W. Long Memorial Hospital and Clinic, Georgia Baptist Hospital, and Anti-Tuberculosis Association. With 233 illustrations. Price $8.00. C. V. Mosby Company, St. Louis, Mo. 1931.

Bedside Interpretation of Laboratory Findings. By Michael G. Wohl, M.D. Associate professor of experimental medicine, Temple University Medical School; chief of Metabolic Clinic, Temple University Hospital and chief of the First Medical Diagnostic Clinic, Mt. Sinai Hospital, Philadelphia, Pa. Illustrated. Price $6.00. C. V. Mosby Company, St. Louis, Mo. 1931.

Medical Jurisprudence. By Carl Scheffel, Ph.B., M.D., LL.B. Price $2.50 net. P. Blakiston's Son & Co., Inc., 1012 Walnut St., Philadelphia, Pa.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, 424 N. Charter Street, Madison, Wis.

A Clinical Study of Addison's Disease. By Leonard G. Rowntree, M. D., and Albert M. Snell, M. D., Division of Medicine, the Mayo Clinic and the Mayo Foundation, Rochester, Minnesota. 12 mo. of 317 pages with 41 illustrations. Philadelphia and London: W. B. Saunders Company, 1931. Cloth, $4.00 net.

This monograph is the most satisfactory treatment of the entire subject of Addison's disease which has yet come to press. The completeness of detail and clarity of presentation are noteworthy. It is refreshing to find the historical background of a medical subject given the attention herein accorded. The recent tendency to reprint the original or significant works of pioneers in fields of medicine finds expression in the complete reproduction of Thomas Addison's original paper on the subject (1855). Students of medical history are familiar with Richard Bright's prior description (1829) of the condition known as Addison's disease, but his photographic description of the clinical picture together with the pathological changes noted in the suprarenal glands did not associate themselves as cause and effect in this master's mind. Indeed, the original description of Addison with certain minor additions made possible by more modern methods of examination, proves adequate at the present time, and the physician unfamiliar with the original source will find this description most satisfactory in its completeness.

The physiology of the adrenals is rather briefly treated. A wealth of material, clinical and laboratory, has been evolved from the 108 cases included in this study. One marvels not only at the mass of material so represented, but in the very adequate analysis of the same. The authors have revived certain findings relative to the skin changes so well depicted in Addison's original plates, namely, the jet black freckles and the pigmentation of the mucous membranes. The demonstration of the calcification of the suprarenal glands by x-ray is an excellent clinical observation.

From the physician's standpoint particular interest attaches to the results from the exhibition of the newer cortical hormone of Swingle and Pfiffner. The results from this new extract have been almost

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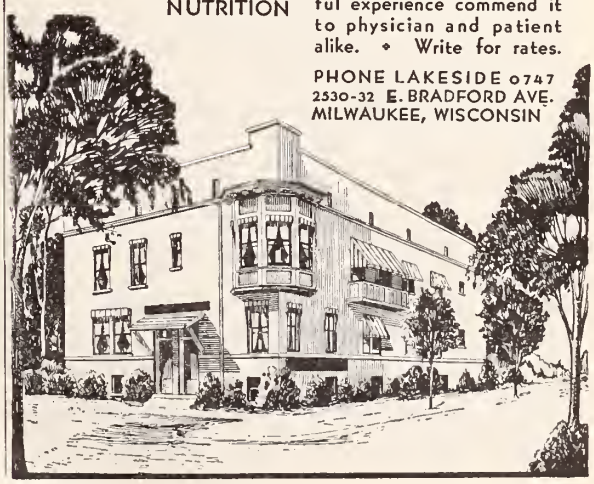

miraculous and it bids fair to replace the rather generally accepted but inadequate Muirhead treatment which originated at Rochester.

The text is well organized for teaching as well as practical purposes, and it will fill a real need in the drawing together and organizing of all worthy sources of information upon the subject. In general, the tinted or colored plates are more satisfactory than the photographs in this monograph. In many details it is a most opportune volume. A single error in spelling, probably typographical, relates to the name of the anatomist, Bauhin, spelled Bahuin on page 18 of the text. W. S. M.

Diagnostic Methods and Interpretations in Internal Medicine. By Samuel A. Loewenberg, M. D., F. A. C. P., associate professor of medicine, Jefferson Medical College; assistant physician to the Jefferson Hospital; visiting physician to The Philadelphia General Hospital, the Northern Liberties Hospital and the Eagleville Sanatorium for Consumptives. With 547 illustrations, some in colors. Second revised edition. Price $10.00 net. F. A. Davis, Company, Philadelphia. 1931.

This second revised edition has been brought up to date in a well arranged manner. The description and explanation of physical findings and the interpretation of the results of examinations by methods of precision are definitely expressed. The field covered necessitates brevity of text, but the author has presented the subjects clearly; the illustrations having been selected with judgment to offset that brevity.

The book is valuable as a text for medical students and as a reference book for practitioners.

J. S. E.

Proctoscopic Examination and the Treatment of Hemorrhoids and Anal Pruritus. By Louis A. Buie, B. A., M. D., F. A. C. S, section on proctology, the Mayo Clinic, Rochester, and associate professor of surgery, The Mayo Foundation, University of Minnesota. Octavo of 178 pages with 72 illustrations. Philadelphia and London: W. B. Saunders Company, 1931. Cloth $3.50 net.

This book is clear, definite, concise, and well illustrated. The conclusions are based on a large clinical experience well controlled. It emphasizes those things every practicing physician should know in the diagnosis of rectal diseases, and the treatment of hemorrhoids and anal pruritus. E. R. S.

Gould's Medical Dictionary. By George M. Gould, A. M., M. D. Edited by R. J. E. Scott, M. A., B. C. L., M. D. Third edition, revised and enlarged, based on recent medical literature; 1538 pages; with illustrations and one hundred and seventy-three tables, including three new tables of bacteria, metazoa, and protozoa pathogenic to man and animals by D. G. Bergey. P. Blakiston's Son and Company, Philadelphia, 1931. Flexible fabrikoid $7.00, indexed $7.50. Rigid fabrikoid, indexed $7.50.

The rapid advances now being made in scientific knowledge and in the application of this knowledge to medical problems make most welcome a new edition of Gould's Medical Dictionary. Gould's first medical dictionary, published in 1890, showed the author to be not a mere compiler but a master in the field of medical orthography. The numerous dictionaries subsequently brought out by Gould exhibited the same mastery in a field made increasingly difficult by rapid growth of science and pseudo-science. Gould's work has been most ably continued by the editor of the recent editions of his medical dictionary, R. J. E. Scott. This third edition gives an admirable presentation of the recent advances in medical science as revealed by medical terminology. "Despite the inclusion of much new matter, the number of pages has not been commensurately increased, as room for a majority of the new words has been made by the topographic compression of the definitions on the particular pages." C. R. B.

New and Nonofficial Remedies, 1931, containing descriptions of the articles standing accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1931. Cloth. Price, postpaid, $1.50. Pp. 481 + LVI. Chicago: American Medical Association, 1931.

This volume is the annual publication of the Council on Pharmacy and Chemistry of the American Medical Association giving the latest authentic information concerning those of the newer medicinal preparations found worthy of the consideration and use of the medical profession. Each year the Council scans the general articles under which the various preparations are classified and revises these to conform to the latest and best medical thought.

A glance at the preface shows that a number of preparations have been omitted because they conflict with the rules that govern acceptance, because their distributors did not present evidence to demonstrate their continued acceptability, or simply because the manufacturers have taken them off the market. Important revisions have been made in a number of the general articles and in the descriptions of various preparations. Among the new preparations that have been found by the Council during the past year to be eligible for admission to the book are: Amytal and Pulvules Sodium Amytal, 3 grains, barbituric acid derivatives for use preliminary to surgical anesthesia; Thio-Bismol, quinine bismuth iodide, sodium potassium bismuthyl tartrate, and Tartro-Quiniobine, bismuth compounds for use in the treatment of syphilis; Scillaren and Scillaren-B, preparations containing the squill glucosides; two new cod liver oil concentrates; Synephrine, a new vasoconstrictor, and synthetic thyroxine.

New and Nonofficial Remedies should be in the hands of all who prescribe drugs. The book contains information about the newer materia medica which cannot be found in any other publication.

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1930. Cloth. Price, $1.00. Pp. 91. Chicago: American Medical Association, 1931.

This book is essentially a record of the negative

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actions of that distinguished body, the Council on Pharmacy and Chemistry of the American Medical Association; that is, it sets forth the findings concerning medicinal preparations which the Council has voted to be unacceptable for recognition and use by the medical profession. Many of the reports record outright rejection or the rescinding of previous acceptances; others report in a preliminary way on products which appear to have promise but are not yet sufficiently tested or controlled to be ready for general use by the profession.

Among the reports recording outright rejection are those on: Avesan (H), formerly Nuforal, a mixture stated to be composed of formic acid, sodium nucleinate, camphor, allyl sulphide and chlorophyll, with traces of salicin and sulphuric ether, marketed with unwarranted claims of usefulness in the treatment of tuberculosis, asthma, and other respiratory diseases; Ceanothyn, once before rejected and still found to be marketed with unsupported therapeutic claims; Collosol Calcium and Collosol Kaolin, so-called colloidal preparations, the former an unscientific mixture of unproved value, the latter a possibly dangerous preparation, and both marketed with unwarranted claims; Ephedrol with Ethylmorphine Hydrochloride, an unscientific ephedrine preparation marketed under an unacceptable proprietary name with unwarranted therapeutic claims; Farastan, an unscientific iodine-cinchophen preparation proposed for routine use in "arthritis . . . and Rheumatoid conditions"; Haley's M-O Magnesia-Oil, a magnesia magma and liquid petrolatum mixture in fixed proportions marketed with emphasis on the "M-O"; Lydin, a testicular extract, marketed with claims of value in the treatment of impotence; and Metatone, a shot-gun "tonic" mixture marketed under a proprietary name with unwarranted therapeutic claims.

Health on the Farm and in the Village. C. E. A. Winslow. Professor of Public Health, Yale School of Medicine. (Macmillan. 1931).

This excellently written, readable survey of the seven years' experience of the Cattaraugus County Health Demonstration indicates what has been accomplished in one county in New York State through cooperative effort, and gives hope that similar success may be obtained elsewhere in meeting the difficult problems of rural hygiene.

This work was begun in 1922 through the cooperation of the local health agencies aided by a grant from the Milbank Memorial Fund. The total annual appropriation for this public health work from all sources has averaged approximately $160,000, $2.20 per capita. The services rendered correspond well with those of an excellent city health organization. Some of the specific items in the demonstration are as follows:

1. Full time county health unit.
2. School health service organized under the county director of school hygiene.
3. Public health nursing service with one nurse per 3,000 population.
4. Tuberculosis control with case-finding machinery, clinic and nursing service and institutional facilities.
5. Consultation service.
6. Laboratory service more extensive than that offered by many cities.
7. Nutritional studies.
8. Care of crippled children.

As a matter of cold figures, an annual saving of five lives from diphtheria, fourteen lives from tuberculosis, and twenty in infant mortality has been accomplished. The importance of mental and emotional mal-adjustments and the value of adequately trained social workers in meeting these problems are stressed. The author concludes that the outstanding lesson in this demonstration is, "the urgent importance, the great difficulty and the high cost of adequate health service for rural communities." P.F.C.

Easier Motherhood. By Constance L. Todd. Price $2.00. John Day Company, Inc., 386 Fourth Ave., New York, N. Y.

Under the caption of Easier Motherhood, Constance Todd, a lay woman, gives an exposition of the Gwathmey method of analgesia in obstetrics. She gives the history of the use of this form of analgesia from its beginning to the present day, citing Gwathmey's experience of over fourteen thousand cases together with reports from numerous obstetricians throughout the country. However, no names but Gwathmey's are mentioned. She cites replies to an article of hers appearing in the Ladies Home Journal, in which the writers, who had endured great pain during their last labors, ask for the names of the persons using the Gwathmey technique in their respective cities. The author also mentions the popularity of elective version in certain localities, stating that its popularity among mothers is due to the shortening of labor. She ascribes the popularity of this method to self-advertising among patients who have been saved many hours of painful labor. She hopes that the same will obtain with the Gwathmey method of analgesia, making it almost necessary for the physicians to use this method because of popular demand.

The book is intended for lay persons, is easily understood and has a minimum of medical terms. However, too much space is devoted to the repetition of what one might call "Testimonials". It seems to this reviewer that the author gives the reader the impression that this method of analgesia is the best that we know today and that those who use other methods, have not kept abreast of the times. However the author does bring attention to the fact that no method of analgesia is foolproof. B. E. U.

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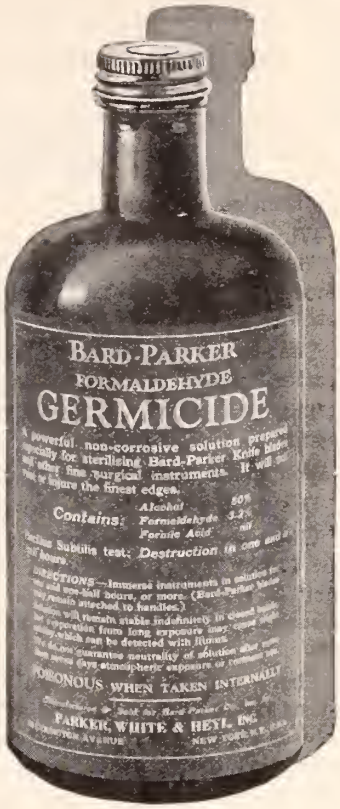

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You are cordially invited to register to be put on the regular mailing list for journals or to receive any of the five services.

This is an invitation to you for September 9th, 10th, and 11th. J. B. P.

PRESS SERVICE

(Continued from page 765)

HAY FEVER

Madison, Wis., Aug. 5—The exodus of hay fever victims to northern Wisconsin has already started. There are thousands of people, however, who have suffered the tortures of hay fever before who will not go this year because of the relief which has come to them through the new pollen treatment. But even this treatment has been efficacious in only 50 per cent of the cases, according to the Educational Committee of the State Medical Society in a bulletin issued today.

"We do not know definitely why one person develops hay fever and another does not," declares the bulletin. "We do know, however, something about the mechanism of the disease. In many respects it is closely allied with hives, asthma and certain kinds of eczema. They all develop in individuals who have for some unknown reason become over-sensitive to certain substances which come into intimate contact with the body—either externally, through the digestive tract or through the respiratory system.

"The treatment of hay fever by desensitization through hypodermic injections of pollen extracts has become very popular during recent years. To carry out this treatment the patient is tested by the 'skin scratch method' with various pollens to determine the plant (or group of plants) to which he is susceptible. The physician then orders the appropriate pollen or pollens and the injections are given on a stated schedule—usually every third, fourth or fifth day. It is generally believed that this treatment carefully carried out will give marked or complete relief in about fifty per cent of the patients so treated. It is certainly worth trying, at least for one or two seasons. Relief by this treatment may not be permanent; it may have to be repeated from year to year.

"One can always get relief if one can take a vacation and go to the northern part of the state. As a rule any location within 40 or 50 miles of Lake Superior, will prove to be entirely satisfactory. Of course, the virtue in this plan is merely that of taking the patient away from his disease, since the offending pollens are not found in the air in this locality."

HOT WEATHER RULES

Madison, Wis., Aug. 12—Hot weather promised for mid-August will result in no discomfort if simple rules of health, dress, diet and exercise are followed.

"Just be moderate," declares the bulletin of the Health Committee of the Wisconsin Medical Society issued today. "'Everyone can 'stand the heat' if the correct rules are observed."

Following are suggestions taken from the bulletin:

"Dress: Your clothing should be loose and airy, of white or light colors. Don't strive to save on laundry bills. Fresh, clean linen will add greatly to your comfort. Clothes soaked with perspiration are soggy and uncomfortable and moreover prevent the proper evaporation from the body surface. If you use colored materials, be sure they are fast colors, such that will not run and stain or poison the body.

"Diet: Drink plenty of fresh, cool water, but not iced water. Drink from eight to ten glasses every day. Sweet drinks should not be taken during the 'hot spells.' Eat regularly but sparingly. Use green vegetables and fresh fruits in large amounts. Eat little meat and heavy pastries. Have your heavy meal in the cool of the evening. Make your lunch simple, such as crackers and milk or a salad: anything so long as it is light. Eat slowly and chew your food thoroughly. Above all things, don't eat when you are tired!

"Baths: Take at least one a day. The water should be tepid. Cool baths are not best during hot weather. Swimming is fine exercise and is very refreshing and, if possible, should be enjoyed every day, but not to the point of fatigue.

"Rest: Plenty of rest is necessary, not only at night but during the day. There is nothing to be gained and much to be lost by overdoing in hot weather.

"Exercise: Should be indulged in in hot weather but you should use judgment in the amount that is taken. Don't reach the point of exhaustion or anywhere near that point. You should absorb a large amount of the sun's ultra-violet rays for next winter's pep but don't try to get it all in one day. Take it at intervals.

"If you are to be happy during the hot months, you will do well to follow these simple rules. Establish a philosophy of composure and deliberateness, refrain from all excesses and use common-sense. Just be moderate."

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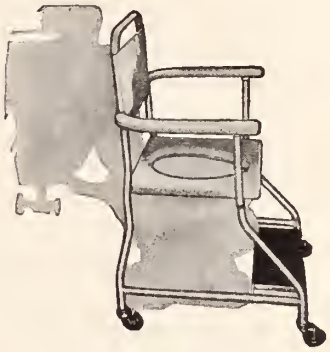

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(Continued on page 780)

The Art and Practice of Medical Writing*

By MORRIS FISHBEIN, M. D.
Editor, Journal of the American Medical Association, Chicago

The Editorial Board of the Wisconsin Medical Journal considers itself particularly fortunate to be able to present this lecture as the third of four to be published in consecutive months.

MANUSCRIPTS

The first paper is almost a perfect manuscript. The author uses the modern spelling of the word "thru." We prefer to spell it "through". The author should have followed the style of the publication for which this is presumably intended.

* * *

As to the pain; this is described by the patient as "gnawing". There are many ways to describe pain. Patients probably describe pain much better than do doctors. A patient will tell you that his pain is "burning," "gripping," "gnawing." The patient can feel it and describe it in much better words than the doctor can. Perhaps it is better, if the patient talks English, to let him describe his pain and to quote him.

This case is changed in this case report from the past to the present.

This case report seems to me an extraordinary record of unnecessary examinations. The minute the man told his history one would have begun to suspect that his was a case of duodenal ulcer. There may have been need for a differential diagnosis of cholecystitis and chronic appendicitis. I question whether it was necessary in such a case to have a non-protein nitrogen determination. The x-ray examination might have been done fairly early. Then we have the basal metabolism test. It is a good thing to have for everybody and is well thought of, but I think there are too many basal metabolism tests made on patients.

Now we get farther along to where the fluoroscopic examination showed a slight enlargement of the thyroid gland. The absence of a lung infection showed up fairly well. The lungs looked clear.

Presuming this paper would be accepted for publication it would be necessary to send it back with the notation: "Please cross out all observations that were unnecessary."

"B. M., a man forty years of age, a butcher." The word, "man" might be unnecessary because to date women do not seem to have invaded that profession. "Same" is a word which should be out. It is even poor in business correspondence.

This should be: B. M., a butcher, aged forty, on August 18, 1930, caught the middle finger of his left hand in an electric saw, which necessitated amputation of the finger.

Here is that word, "present" again. He says: "Infection was present." It would be much better to say: "The finger was infected."

It is important if you use an antiseptic to specify the antiseptic. State whether you used hychlorite, metaphen, benetol, zonite, lysol, or bichloride of mercury.

Not one of the references in this bibliography would be suitable. A correct reference must include, first of all, the name of the author with his initials; then after the author's name with his initials, the title of the paper. If the reference is taken from a book then the date of the publication and the year of the publication should be specified. For instance: "Leipzig: 1912," or "Berlin: 1912." Then after that should follow the volume, page, month and year.

Yesterday I received a letter containing quite a long bibliography. The letter went to the library and about an hour was spent on it. When I looked at it I wondered what the man was going to do with the information. He sent us a list of authors' names, and he said: "Will you please supply the

* Presented as one of a series of lectures offered under the joint auspices of the Medical Society of Milwaukee County and the Extension Division, University of Wisconsin, in Milwaukee, 1931.

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed care Wisconsin Medical Journal.

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initials and the names of the authors in the instances where they are not given." He wanted the original references. He knew that no bibliography would be passed upon by any respectable publication in that form.

The first man's name was Schmidt. We took it for granted that he was a German so we got down our "Minerva" which contains a complete list of important scientists in all parts of the world, and we found about two hundred Schmidts listed.

In this manuscript every action is described in the present tense. It should have been in the past tense because the author is describing something that happened six months before he wrote. One should not say: "The patient was seen on a certain day," and then add: "He is . . . " because he was seen and what follows should be written in the past tense. . . . Here is a case report on "Septicemia." A postmortem was held, and in presenting an anatomic diagnosis the important observations should be given first. Diphtheritic septicemia was the cause of death and obviously the cause of the other conditions. Now to report that patient on the death certificate as a death from heart disease is wrong. That patient's death was caused primarily by diphtheria. Heart disease was a secondary cause.

I want to call attention again to the words, "markedly enlarged." Throughout practically all these manuscripts I find those two words used. They have become the most abused words in medical writing and should be avoided as a descriptive term.

Here is a manuscript which begins in a way that Mrs. Mellish says one should never begin. In her chapter on "Don't" she says: "Don't begin a paper by saying that the case is a rare one and seems therefore to warrant being reported".

It should begin: "On August 20, 1930, . . ." It is not wise to say who sent you the case: the College of Surgeons might find it out.

REVISION OF THE MANUSCRIPT

An author's style is his own. It should be as personal as his clothing, although Hart–Schaffner and Marx and Richman have destroyed personality even in clothes. It should have all the attributes of his character. It should indicate his education, his feeling, perhaps for esthetics.

Among the best specimens of scientific literary style are quotations taken from Sir William Osler. Read a few pages in the Osler text book on "The Practice of Medicine." You will find that the prose literary style of Sir William Osler has within it the rhythm of poetry. The sentences of the great masters are constructed to correspond with natural pauses, with the rhythm of human respiration.

Perhaps the only way to get that style is to practice it. There are other methods which will benefit style, most important being the reading of competent writers. I do not mean translations from the German or French for translators are seldom competent authors. Many modern writers of fiction have good style, but their works generally will not be scientific.

In general, the women writers today are superior to the men in literary style; for example, Willa Cather, Zona Gale, Edith Wharton, and Ellen Glasgow.

Avoid verbosity! Read the works of Sir Thomas Clifford Allbutt and Sir William Osler. If you care for medical history I would suggest the writings of Dr. Charles Singer or those of Sir Thomas Clifford Allbutt. In those writings you will find something helpful to your style and diction. These men do not waste words; they say what they have to say with a minimum number.

Deletion of unnecessary words will improve grammatical construction and style of expression, and make reading with understanding easy. One example of such deletion appears in "The Art and Practice of Medical Writing." Quiller–Couch who is responsible for it devotes a chapter in "The Art of Writing" to verbiage.

He says: "A clerk of a Board of Guardians had to record a minute relative to the burial of a pauper. The minute read: 'In the case of John Jenkins, deceased, the coffin provided was of the usual character.' Sir Arthur says: "First, it is superfluous to tell us that Jenkins is deceased; the fact that he needs a coffin is sufficient evidence. Then, 'In the case of' is superfluous, for Jenkins did not have a case; he had, and needed, only a coffin. Further, the coffin was not 'of the usual character,' for coffins have no character. The clerk of the Board of Guardians should have said: 'John Jenkins was provided with the usual coffin'."

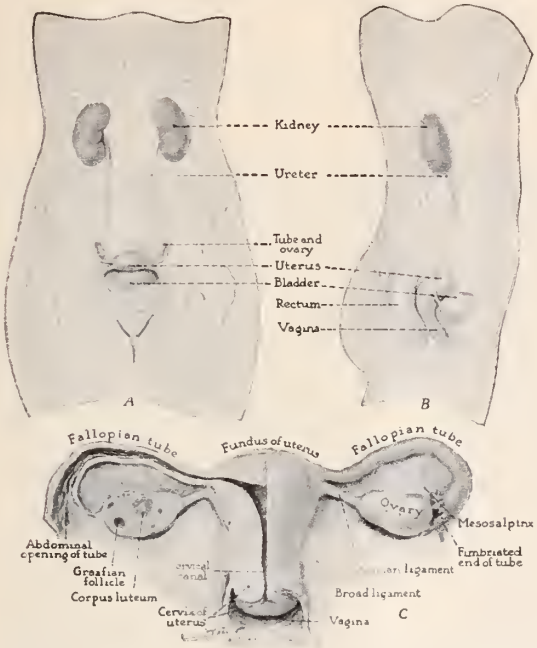
Doctors seem particularly prone to repeating themselves, especially with regard to the phrase, "the fact that." Over and over this phrase is repeated to the point of exhaustion. Many sentences begin with, "It is a question long debated in the medical profession." Such introductory phrases should be omitted.

REVISION

The letters accompanying manuscripts which I read to you emphasized revision. A man in Illinois stated that he had revised his manuscript four times and he thought that sufficient. A trained writer need not revise his manuscript seven times, but an untrained writer may have to revise his manuscript fifteen times.

Anatole France, the great French writer who received the Nobel prize for literature, used to revise his manuscripts seven times, and his technic of revision was unique. He used to go over his manuscript the first time for the purpose of correcting it generally; then he would go over it again for correction having to do with the soundness of presentation. Then after reading it over again and again he would send it to the printer to be put into type. Then after it was put into type he would look at it and if it did not just suit he would take a scissors

ANATOMICAL STUDIES



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and cut out a word, the position of which seemed to him doubtful. He would take the word and move it around to different places in the manuscript in order to find out just where it sounded best or at just what point it had the most emphasis. There are certain rules of emphasis which a trained writer recognized, but which are not noticeable to the untrained writer, though they may be exceedingly important in making the meaning clear. For example, emphasis is destroyed by placing too many adjectives before a noun.

In "The Art and Practice of Medical Writing" there are examples of the revision of manuscripts. (pages 116 to 118) The example presented was a paper selected purely at random. In this particular instance the author did not present his material in good literary style. A sentence containing 208 words was rewritten to make several sentences totalling approximately eighty words.

Here is a paper without name and address at the top. There really will be no value to the author unless he has his name and address on the paper. It is entitled, "Sacroiliac Strain." I requested a case report and this is an essay. Strain and sprain are terms of vague connotation. You say "He strained himself;" that brings lots of pictures, but not the exact description of what happened. The author says, "In this case report we will confine ourselves. . . ." Perhaps we will find out before we get through that this is a case report. Do not use the term "we" unless there are two authors. Editors are jealous of the word "we". Do not say, "We will concern ourselves" if you want to concern yourself. Say, "I will concern myself."

The author says, "Many individuals who are suffering." Individuals are abstract. It is better to say: "Many persons suffer from arthritis. . ."

Then some medical jargon follows, and this sentence, "These patients exhibit inability to put one foot down." Just say, "They are unable to put one foot down." They may exhibit it, but not purposely. Then another sentence follows which is extremely bad grammar. "When the patient is placed on his back and in perfect alignment, the legs are swung clear and brought close together to compare the length of both limbs." Why does he do it; who tells him to, and how?

Here is a case report of a lady who had an inferiority complex that made her feel superior.

"Mrs. T., housewife, Protestant, college graduate.". Maybe that was why she felt superior. "Was admitted under compulsion." Incidentally, there you have again the importance of eliminating or including the sociologic data. In this woman's case I would say that certain sociologic data are important: I would say the more data having to do with the social aspects of the case, the better.

"Married fourteen years." That certainly is important if she was married for that length of time and had no domestic disturbances.

"Housewife: Protestant." The latter is important because she may have had inhibitions that a Catholic would not have.

"College graduate." That is important.

"Admitted under compulsion." That is most important.

"Her mother and the only other child, a sister, have both been operated on for the same trouble. One normal pregnancy: a feeble minded daughter, eleven years old." There are three perhaps totally unrelated phrases. Now the manner of describing the progeny of a pregnancy gives a great opportunity for literary style. It would have been better said: "One normal pregnancy yielded a feeble minded daughter, now eleven years old." He means to tell us that the progeny was not so good. The passage of time would be important—eleven years.

"Personal history: Has always enjoyed good health." Of course that is not meant. "Personal history: The patient has always had good health." There are people who enjoy good health and there are people to whom good health is absolutely anathema. They do not want to feel well. . . .

"She was bright in school but of a wilful nature." If she was bright in school, what has that to do with a wilful nature? If she was bright she might not have been wilful. We might say, "Her teacher stated she was wilful."

"Her early residence was in a small town where she was a leader." That is important in a case of psychiatric interest. It would not be important in the case of a woman having one kidney.

"She was of a proud nature and was over-indulged." Better said: "She was proud and over-indulged."

"She was a social climber. In retrospect personality changes were noted four or five years ago." Write it down again. Engrave it somewhere—the word, "ago". It will confuse the reader every time. It should be substituted by an exact statement of time.

"She was admitted to a psychiatric institution. Her husband now believes three years ago. . . ." When is three years ago? Is it three years before the four or five years ago, or is it three years since the four or five years ago?

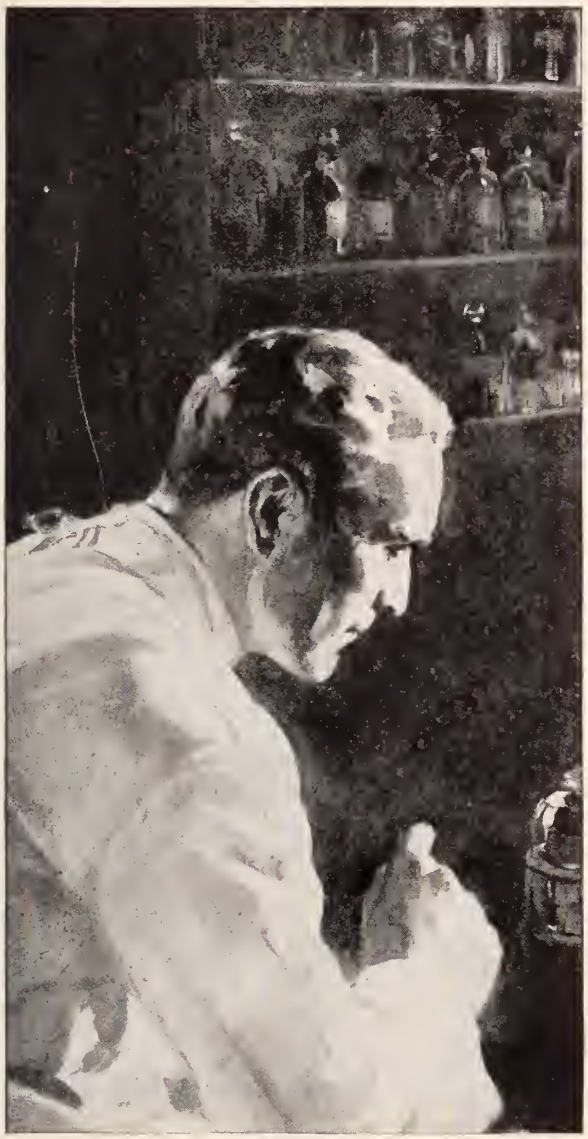
"She threw herself into the construction of a country home." The sentence raises the question of a choice of words and terms. I gave it a lot of consideration and I left it. It is absolutely descriptive of a person of that type. She would throw herself into anything. She would put ten times more energy into a task than might ordinarily be required for its accomplishment. So the author says, "She threw herself into the construction of a country home." Make sure your terms express the picture you are trying to convey.

A lack of the proper articles before certain words follows, and the sentence, "The patient continued her restlessness." Better said, "The patient continued to be restless."

"A little over two years ago she entered a private institution." Here again "two years ago."

A FEW CONTRIBUTIONS TO THE

Modern Materia Medica



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. . . This is good writing. It gives an exact picture. Whether the author intended it to be so or not, it is good. The reader gets the cumulative effect of a series of short, snappy statements.

Bear in mind that the patient could not complain of an insomnia complex. She would not have said, "The complex with which I am suffering is insomnia." It would be better written, "The patient stressed insomnia as her chief complaint."

When this author is actually describing what he sees he writes well, but the moment he starts to theorize his language becomes involved. His narrative is good.

The use of a noun as a verb is just about as bad as the use of a noun as an adjective. A noun should be used as a noun.

Here is a case report on which the author forgot to put his name. It reads: "The contention of the causes for intercranial hemorrhage. . . ." He probably meant: "The theories as to the causes of intercranial hemorrhage have changed much, or have changed anything but 'markedly'." The man used the word in the first thirty lines five times. I have criticised and emphasized again and again the too frequent use of the word, "markedly."

One of the best points to be noted about this paper is that the writing is rhythmical. I noticed often clauses having two pauses of equal length.

. . . "The reason for this section was that the mother's heartbeats had increased markedly." Had they increased in extent, in volume, or in number? Had the pulse rate increased? What does he mean? I think that he means probably that the mother's heartrate became much more rapid.

"It was thought best to do a delivery." That, of course, is medical jargon. He means to say: "It was thought advisable to deliver the patient immediately."

"No forceps or any undue pressure was used in extracting the baby from the uterus." This is ungrammatical. The author means to say that "Neither forceps nor undue pressure, etc."

In revising your manuscripts be sure you write the word "pounds" in letters and do not use the sign. Seven pounds means seven pounds and 7# may mean seven spaces in the printing business.

The word "very" should practically always be left out. "Very" has numerous connotations. Look over the Great Oxford Dictionary; not the pocket edition or the larger size, but the one that comes in twenty volumes. There are, I believe, some twenty-four pages on the definition of the word "set." The word "fix" has, I think, the next largest number of pages. You have heard the expressions: "I will fix him," and "He is in a tough fix." The word, "very" has tremendous usage, such as the phrases: "Very good, Eddie," and "Very large."

A single number or figure occurring alone should always be written out. When you are giving a long list of dates, do not write them out.

"Hospitalization was advised, but refused. The patient decided to wait awhile yet." That must be Milwaukee English. I substituted for "wait awhile yet"—"The patient decided to delay." That is saying everything the author wants to say.

"The diagnosis or differential diagnosis lies between lobar and pulmonary pneumonia." Then he says: "Pulmonary embolism, which diagnosis was finally made." He has misused the relative pronoun "which." He meant to say: ". . . the final diagnosis"

He says: "In this particular case. . ." If one said, "This particular patient" the meaning would be different, but the author does not mean that the patient was particular; he means "this case".

The word, "findings" is an overused word.

The blood picture is interesting, in that, "On the first visit the white blood cell count was six thousand higher than on the second visit, and (get this) the *R. B. C.* was *vice versa.*" Did he mean six thousand lower than on the previous visit?

. . . The blood count on entry was: 12,600 white blood cell count, and 4,700,000 red blood cells. At this time the white blood cell count was 6,000 higher than on the second visit. But there was another visit before the last visit.

Here is an unusual case of general paralysis. The author says: "A man aged 60, single, came in with his history. That is wrong because he didn't come in with the history. It probably had to be extracted from him.

I have told you before not to call a human being a male or female. Those terms are used in the Bible but that is about the only reference we permit to them; from then on people became human.

BEAUMONT MEMORIAL CONTRIBUTORS

(Continued from page 774)

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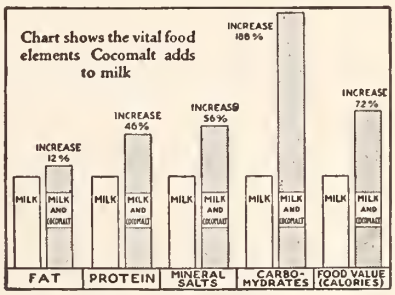

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Data Announced on Distribution of Medical Services in the State

A complete compilation showing the distribution of physicians by counties and the estimated population that each must serve, has just been compiled by the State Medical Society. The compilation would seem to indicate that on the average there is a physician to each 980 people in the state. There are striking differences from the average in Dane county where there is one physician to each 462 people and in Taylor county where there is but one physician to each 2942. Accuracy of the figures is in some question in both Dane and Milwaukee counties because of the number of physicians whose main efforts are in teaching and yet whose time is not entirely devoted to that endeavor. The figures for the state follow:

County	Estimated Population 1931	Number of Practicing Physicians	Population per Physician
Adams	7,875	3	2,625
Ashland	20,706	21	986
Barron	34,303	25	1,372
Bayfield	14,786	8	1,848
Brown	71,085	66	1,077
Buffalo	15,301	9	1,700
Burnett	10,173	6	1.696
Calumet	16,810	12	1,401
Chippewa	37,428	31	1,207
Clark	34,069	20	1,703
Columbia	30,507	37	825
Crawford	16,782	14	1,199
Dane	115,068	249	462
Dodge	52,327	32	1,635
Door	18,093	11	1,645
Douglas	46,264	37	1,250
Dunn	27,044	16	1,690
Eau Claire	41,619	41	1,015
Florence	3,785	2	1,893
Fond du Lac	60,259	74	814
Forest	11,245	7	1,606
Grant	38,411	36	1,067
Green	21,900	22	995
Green Lake	13,817	12	1,151
Iowa	19,892	17	1,170
Iron	9,900	5	1,980
Jackson	16,340	8	2,043
Jefferson	36,961	43	860
Juneau	17,069	13	1,313
Kenosha	64,476	57	1,131
Kewaunee	16,032	10	1,603
La Crosse	55,565	55	1,010
Lafayette	18,514	20	926
Langlade	21,551	15	1,437
Lincoln	21,071	16	1,317
Manitowoc	59,377	41	1,448
Marathon	71,166	46	1,547
Marinette	33,447	23	1,454
Marquette	9,282	9	1,031
Milwaukee	743,844	1,006	739
Monroe	28,746	24	1,198
Oconto	26,014	14	1,858
Oneida	16,089	12	1,341
Outagamie	63,558	54	1,177
Ozaukee	17,500	12	1,458
Pepin	7,447	5	1,489
Pierce	20,981	20	1,049
Polk	26,537	16	1,659
Portage	33,845	29	1,167
Price	17,161	8	2,145
Racine	91,343	81	1,128
Richland	19,495	16	1,218
Rock	75,012	99	758
Rusk	16,049	8	2,006
St Croix	25,390	21	1,209
Sauk	31,978	30	1,066
Sawyer	8,942	4	2,236
Shawano	33,470	16	2,092
Sheboygan	72,367	67	1,080
Taylor	17,649	6	2,942
Trempealeau	23,850	22	1,084
Vernon	28,465	24	1,186
Vilas	7,359	5	1,472
Walworth	31,231	40	781
Washburn	11,076	7	1,582
Washington	26,635	21	1,268
Waukesha	53,333	67	796
Waupaca	33,444	35	956
Waushara	14,198	5	2,840
Winnebago	77,895	69	1,129
Wood	38,187	32	1,193
Total	2,969,390	3,028	980

Therapeutic Notes

NEW AND NONOFFICIAL REMEDIES

In addition to the articles enumerated previously the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Abbott Laboratories:
- Capsules Pentobarbital Sodium—Abbott, 1½ grains.

Eli Lilly & Co.:
- Pulvules Pentobarbital Sodium — Lilly, 1½ grains.
- Elixir No. 229 Ephedrine Sulphate, 2 grains.

Parke, Davis & Co.:
- Ventriculin, 100 Gm. Bottle.

Sandoz Chemical Works, Inc.:
- Sandoptal:
  - Tablets Sandoptal, 0.2 Gm.

Nonproprietary Articles:
- Pentobarbital Sodium.

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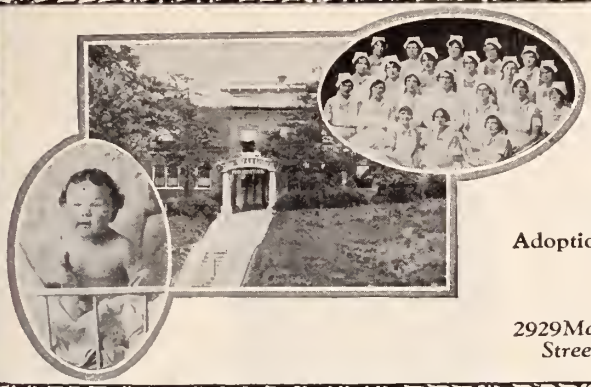
The following products have been accepted by the Committee on Foods of the Council on Pharmacy and Chemistry of the American Medical Association for inclusion in Accepted Foods:

Vitamin D Bond Bread (General Baking Co., New York City).—A white bread prepared by the straight dough process containing an added special nutrient vitamin D equivalent to that of three teaspoonfuls of standard cod liver oil for each 24 ounces of baked bread (140 vitamin D units as defined by the Council on Pharmacy and Chemistry). This bread is an adequate food source of vitamin D for normal nutrition.

Lactogen (Nestle's Milk Products, Inc., New York).—A spray-dried modified cow's milk containing added milk-fat and lactose. The prescribed dilution approximates human milk in percentages of milk-fat, protein, lactose and total minerals and in



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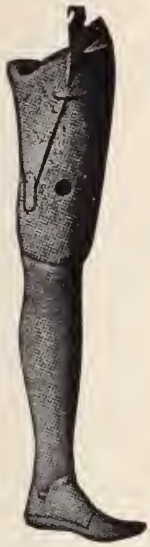

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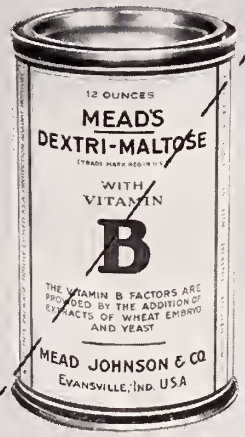

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VOLUME XXX
NUMBER 10

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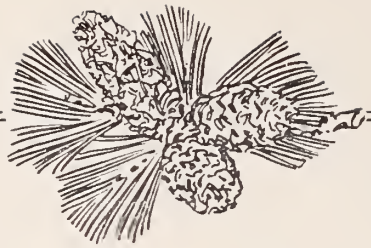

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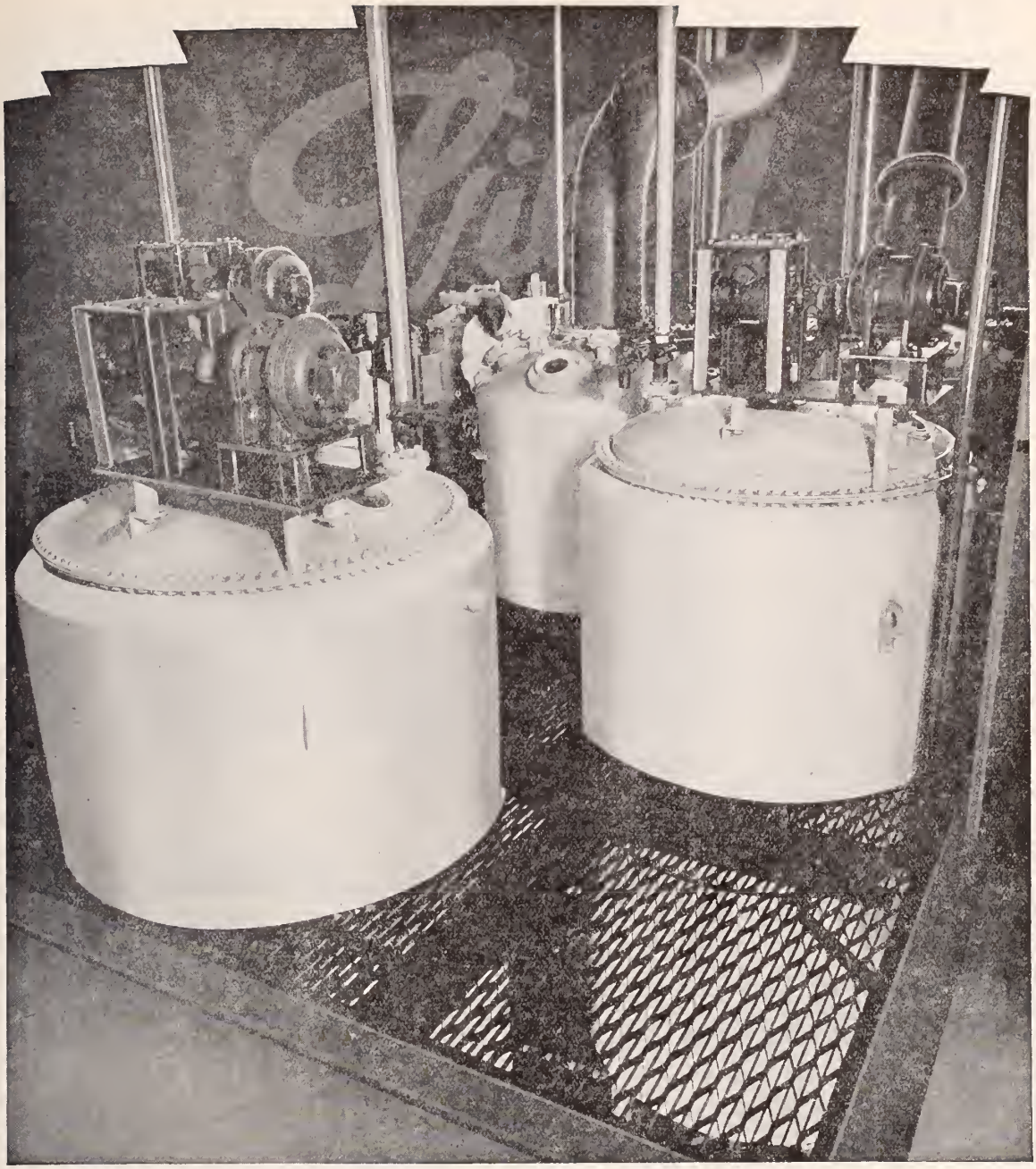

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[1] Editorial, Storage of Calcium, J.A.M.A. *96*:197 (1931). [2] Sherman, H. C. and Booher, L. E., The Calcium Content of the Body in Relation to that of the Food, Proc. Soc. Exper. Biol. & Med. *28*:91 (1930).

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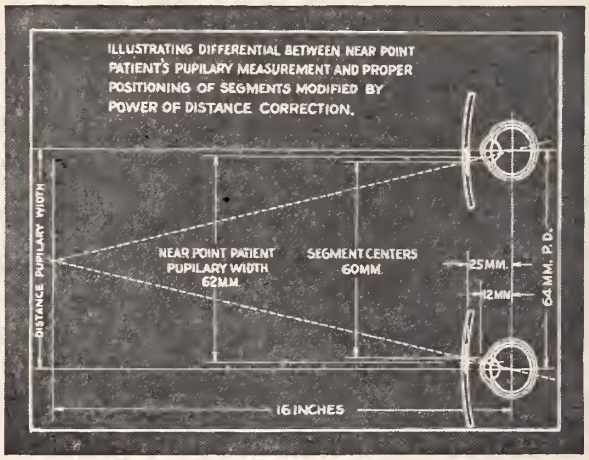

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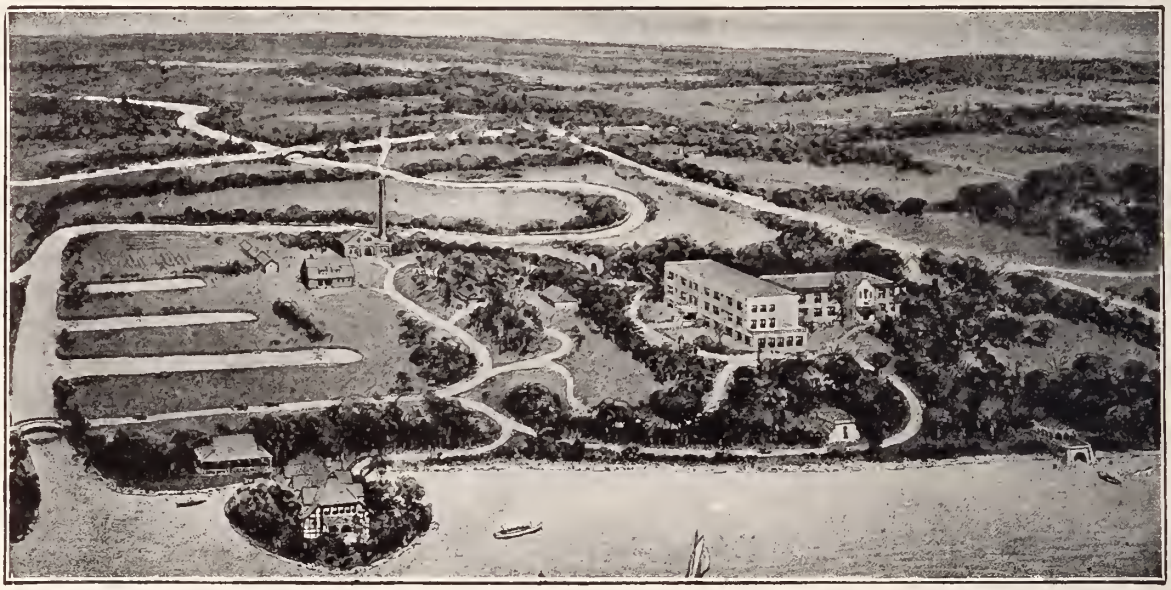

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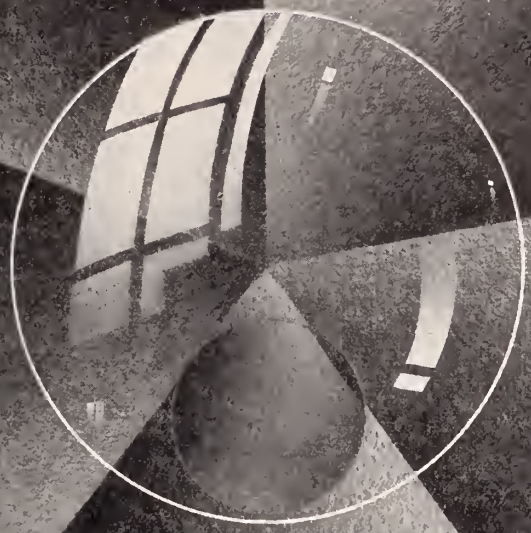

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The Wisconsin Medical Journal

Volume XXX OCTOBER, 1931 No. 10

A Brief Outline of Public Health Development in Wisconsin*

By C. A. HARPER, M. D.
State Health Officer, Madison

Fifty-five years have elapsed since the State Medical Society of Wisconsin has been told of the child born to that organization in the person of the State Board of Health.

Twenty years prior to the enactment of the medical practice act the Wisconsin State Board of Health was officially organized. A discussion of the proposition during the annual meeting of the Society in 1874 resulted in the appointment of a committee of three consisting of Dr. Griffin, of Fond du Lac, Dr. J. B. Whiting, of Janesville, and Nicholas Senn, of Milwaukee, for the purpose of petitioning the state legislature for the establishment of an official health department. The committee reported at the next meeting, in 1875, that their efforts had been ineffective.

In view, however, of the desire of many men in the State Medical Association that something be done to prevent the enormous loss of life from certain diseases, afterwards to be known as communicable diseases, the committee was continued. Renewed efforts were put forth. At the annual meeting in July, 1876, the committee made the following report:

"Previous to the meeting of the legislature in January, 1876, your committee had given the subject some attention and had proposed to themselves a line of effort, when they were informed of the action of a similar committee appointed for a like purpose by the Sauk County Medical Society, of which Dr. C. Teal, of Ironton, was chairman. The action of the Sauk committee had progressed so far that your committee felt it was best to confide the matter largely to them. We are happy to report that as a result of their efforts a bill was passed which became a law on March 31, 1876, entitled Bill 333-a 76. It was introduced by Silas J. Seymour, of Reedsburg, Sauk County, a farmer born in New York."

Wisconsin was the tenth state to develop an official health department and the Board was granted an appropriation of $3,000 annually. Many obstacles had to be overcome; even Governor Ludington at that time apparently did not look with favor on this new departure in government. The Governor, however, had many personal friends in the medical profession, all of whom encouraged him to sign the measure. To the medical men of the 70's official public health in Wisconsin owes its origin—a procedure that undoubtedly not only meant much to the citizenship of the state but also to the profession itself.

The first meeting was held June 27 and 28, 1876, and upon its organization Dr. Griffin was elected president and Dr. Reeve, of Appleton, its secretary. It will be remembered that Dr. Reeve had been president of the State Medical Society in 1875 and that at the close of his term of office as president he was elected secretary of the State Medical Society, filling two positions and intimately connecting the two lines of activity.

The voluminous records show that the Board carried its responsibility seriously. These men were pioneers in a field surrounded with much mystery,—no bacteriology, only the rudiments of chemistry, no sanitary engineers, negative vital statistics, practically no precedents and a public imbued with the idea that fog, miasma, dampness and the will of the Lord determine its destiny. Apparently, also many physicians of that day had been taught to have the same faith.

Since the origin of the Board, 39 physicians, a Civil War general, and a professor of chemistry have guided the destinies of the public health program of the state. The of-

* Address of the President presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Sept., 1931.

fice force during the first 30 years consisted of a secretary, Dr. Reeve, who served for 18 years, and a part time assistant. Dr. Reeve's successor, Dr. Wingate, served for 10 years with one assistant. During the first two years of the speaker's secretaryship, a stenographer was provided. That period saw much progressive legislation proposed but unfortunately very little law enactment. The appropriation had increased from $3,000 to $5,500 annually. Of the latter amount $1,000 was specifically designated for the purpose of printing. In 1877 the Board held six meetings, consuming eleven days.

That it was the intent of the people of this country that public health should form a part of official government is found in the fact that the territorial legislature of 1839 provided that the officials or trustees of any town, village, or city should constitute a board of health. The legislature of the state in 1849 reaffirmed the territorial provisions and further provided that the Board may appoint a doctor of medicine who shall be health officer and shall hold office during their pleasure.

CHOLERA

Asiatic cholera, which had terrorized many countries of the world and had endangered the citizenship of the United States, is said to have been a vital factor in engaging the attention of the public and the Wisconsin legislature, and added an additional impetus to the development of a public health program. In the earlier days cholera appeared to be such a dominant factor in the minds of the people that the Board frequently deplored the attention given to cholera and the indifference toward the more destructive diseases, later classified as communicable diseases. The Board further lamented the fact that the ravages of these various diseases will never be accurately known, due to the absence of any reliable vital statistics.

VITAL STATISTICS

As you know, the enforcement of the vital statistics law, which was enacted in 1852, was under the control of the Secretary of State. Its value and the compliance on the part of those held responsible for reporting statistics may be summarized in the words of Dr. Griffin:

"The Secretary of State's report for 1875 (23 years after the law enactment) shows the population of Dane County as 52,798 and the number of marriages as 378. There is neither a birth nor a death in the county of Dane. Wonderful people of Dane! Where nobody is born and nobody dies! And with Dane so with Dodge with its population of 48,-394, Kenosha, and other counties."

To show that the Board was correct in its contentions, it is found that the 1890 federal census listed over 18,000 deaths, while the records in the office of the Secretary of State showed less than 10,000. Many attempts were made by the Board during its first thirty years of existence to change the legislation; to obtain reliable vital statistics, which is the bookkeeping of public health, and while the law was changed from time to time the changes were such that the procedure of obtaining the records proved impractical. In 1904 the legislature transferred the vital statistics to the State Board of Health and made a special appropriation. In 1907 the uniform registration law was enacted and in 1908 Wisconsin was admitted as the seventeenth state in the registration area. 1917 marked its entrance into the registration area for births.

TUBERCULOSIS

The early 80's brought a ray of light to the Board when Dr. Koch discovered the bacillus of tuberculosis and established its communicability. The State Medical Association in its annual meeting in 1883 endeavored to assist its struggling child by adopting the following resolution:

"*Resolved,* That in consideration of advances made as to the knowledge of the cause of consumption and the now known infectious character of the disease, we will use all the means in our power to have the phthisical members of the family as much as possible separated from the healthy members, and we recommend the State Board of Health to take measures to have such persons separated from the well in our public institutions."

The Board appreciated this continued and intimate co-operation of the State Medical

Association and in its reply favored the adoption of such precautions in general but maintained that the comfort of the victims and the companionship of friends must be given careful consideration.

Since this procedure initiated the subject of tuberculosis it is undoubtedly of interest to this society to have related some of the procedures relative to the prevention and control of this dreaded malady. In 1901, Governor LaFollette appointed a committee of three to study the subject of tuberculosis and make a report to the 1903 legislature. Following this report the legislature of 1905 provided for a new commission of five, to be known as the Wisconsin Tuberculosis Commission, of which the secretary of the State Board of Health was to be a member. The remaining four were appointed by the Governor. This new commission introduced a bill in the 1905 legislature providing for a state tuberculosis sanatorium for incipient cases and an appropriation of $90,000 for grounds and buildings, with $25,000 additional annually for current expenses. The law provided that this commission should have charge of the selection of a site, provide plans for buildings, and the medical and nursing management. The State Board of Control handled the finances.

Of the many proposed sites examined by the Commission, the location at Wales was finally selected.

The joint relationship with the State Board of Control and the Commission worked out very satisfactorily for a number of years. Finally, however, the Commission felt that it should be relieved of its labors and therefore had a bill passed in the legislature putting the institution entirely under the jurisdiction of the State Board of Control.

In 1908 the International Congress of Tuberculosis was to meet at Washington, D. C. The officials of that Congress implored the Wisconsin State Board of Health to put on an exhibit. The Board had no money for this purpose but authorized its secretary in connection with the director of the State Laboratory of Hygiene, Dr. M. P. Ravenal, to solicit funds. A sum of $1,325 was obtained and an exhibit prepared and honorable mention received from the officials of the Congress. Also prizes were offered in competition with all the countries for the best law relating to tuberculosis. The Wisconsin law received first prize and the Board awarded a medal.

The State Sanatorium at Wales was principally for the incipient tuberculous patients. The problem of handling the advanced cases was discussed at a number of the Board meetings. The secretary was therefore authorized to read a paper before the 1910 annual meeting of the trustees of county institutions on the importance of developing in the counties, either with or independent of the county institutions, provisions for caring for those not eligible to the state institution.

CONTAGIOUS DISEASE

There were many serious problems confronting the Board. No problems, however, were deemed so vitally important as the prevention and control of certain diseases designated as contagious diseases, and therefore these diseases were made the main object of attack. The Board had estimated and made a record that in one year in the 80's there were 9,714 cases of diphtheria with 2,202 deaths; while the official record for 1930 was 79 deaths and 799 cases. In spite, however, of the tribulations through which the Board passed, its continual educational campaign was not without some results. The prevalence of diphtheria began to slowly recede, but an equally serious problem presented itself in the prevalence of typhoid fever. This disease began to show a rapid increase and probably reached its maximum in 1910, with 558 deaths in the 5,000 cases reported.

With the discovery of the Klebs-Loeffler bacillus and the bacillus typhus it was readily seen that laboratory aid to the Board and to the medical profession was fundamentally essential. In 1895 Dean H. L. Russell of the University was designated consulting bacteriologist to the Board. Fifty four examinations of water supplies were made in 1897. In 1903 a bill was passed appropriating $1,500 a year for two years

from the university laboratory funds, thus initiating the State Laboratory of Hygiene. Its growth, however, was slow. From 1903 to 1907 only 1,568 examinations were made. In order to improve the efficiency of laboratory facilities the present State Laboratory of Hygiene was established in 1911 and its direction was put under the president of the University, dean of the medical school, the president and secretary of the State Board of Health. The medical profession in the northern section of the state felt that the distance to Madison was too great to make possible that quality of laboratory service that is so essential in certain types of acute cases of communicable diseases. Therefore the State Board of Health in 1915 was able to obtain legislation to create the laboratory of the State Board of Health which was located at Rhinelander. Again requests were made by health officers and physicians for additional laboratory service. In 1917, therefore, provisions were made for not to exceed seven state cooperative laboratories. In 1930, 124,859 examinations were made in these laboratories.

Time will not permit to enumerate the development of the various activities of the Board. In 1917 special legislation with appropriation (in 1919) was enacted for venereal disease prevention and control. In 1920 a report by the director of the venereal disease division showed that 803,746 Wisconsin residents had been instructed in some manner concerning venereal disease prevention. In 1919 the bureau of maternity and child welfare and the bureau of public health nursing were created. Other activities were placed under the Board by the legislature, such as the licensing and regulation of plumbing, hotels and restaurants, registration of nurses in 1913; the barbers sought cover of the Board in 1915 for licensing and sanitary regulations; the embalmers have been regulated since 1901, and the cosmeticians since 1920. The Board had employed the services of a consulting sanitary engineer from time to time until the amount of work made it necessary, in 1919, to create a bureau of sanitary engineering.

A TRIBUTE

Thus your child of the 70's is still with you. Its household has increased from two at its origin to 94 full-time and 8 part-time workers. It will be readily seen, therefore, that your responsibility has grown. No greater testimonial can be given to a State Medical Society than the testimonial that during the 55 years of the public health program of the state the State Medical Society has always sponsored public health procedures.

Scientific discoveries in the field of medicine have directed materially the paths of official public health. They have also brought to the horizon a new field in general medicine. The scope of preventive medicine in the future should approach the curative procedure. In this the medical profession must assume and direct its responsibility.

Specialization in medicine tends to obliterate the family physician. Thus the families are without the usual medical guidance. The profession requires the aid of government, the machinery of a public health department, for educational work. Your state health department therefore talks to the public in terms of periodical health examinations, immunization, proper prenatal and postnatal care, normal nutrition especially as it pertains to children. The public requests such procedure. The state demands it for its own protection. The great medical profession is fully equipped to fulfill all such expectations. It may not be accomplished as it should be without a better understanding of the community problem by the profession and a better, more organized medical program, especially as it relates to local units. Public health, therefore, is not only demanding individual but mass consideration.

The medical profession, in organizing to meet the new change of events, will continue its whole-hearted cooperation with the official public health programs developed to meet conditions as they arise. The medical profession needs constructive public health work. Public health cannot advance as it should without the continued cooperation of the medical profession.

Social Medicine*

By OTHO A. FIEDLER, M. D.
The Sheboygan Clinic

Coming events cast their shadows before, but one of the most interesting phenomena of history is the fact that the large proportion of mankind has usually been blind to the shadows that have been cast. If they had possessed foresight, George could have retained his colonies, Charles his head, and Louis the bastille and his throne. The study of historical and social data should lead us to a determintaion of what shall take place within a given period. Those of you who have read "The Adams Family" know that both Brooks and Henry Adams attempted to make of history a very definite science. They searched for a basic or fundamental law under which it would be as possible to predict the time and nature of future events as it is to predict an eclipse of the sun or the appearance of a comet. I do not think that either one of them was satisfied that he had established such a law, though it is true that ten years before the event, Henry predicted what was realized in Einstein's theory of relativity. If we could thoroughly systematize the data and material of our social knowledge, it might be possible for us to predict in some degree the ultimate outcome of the chaotic state in which society and medical service find themselves at the present time. Any attempt at such prediction must be based upon a survey of the past, to note in what direction and along what lines social progress and human happiness have developed.

To go back to the dim edges of history, that is recorded history, somewhere about one thousand years before Christ, an examination of society and the state reveals an almost omnipotent military dictator, who, with a few followers, holds the great mass of human kind in bondage. He has the power of life and death over his subjects, determines their liberties, their economic condition, is the arbiter of their lives and destinies. Not until 1215, when the barons forced John's signature upon the Magna Charta, did the common man find freedom and the assurance of any of his liberties. Then in succession came security of life, freedom of person, right to hold property, and the franchise which secured political equality to the members of society. This state however was not attained throughout the world at once. In France after the Napoleonic era, in Japan within the memory of our grandparents, and in Russia only within our own time, have individual rights and benefits been obtained which we regard as inherent rights of every man.

The democratization of society in America seriously affected the political life of Europe and led ultimately to the emancipation of all the white people of the world, until everywhere men of the Caucasion race are political equals in their respective countries and the individual by a slow and gradual process has evolved from a slave to a man with sovereign rights. As a consequence governments have become in the words of Lincoln, "governments of the people, by the people, and for the people". Good laws are such as secure to the whole body politic the benefits of legislation without conveying special privilege or advantage to anyone or to any class. It has long been the policy of the legislative committee of your Society to act in legislative matters on the fundamental principle that the profession must ask for nothing, recommend nothing in the way of legislation that has not for its object the general wellbeing; that the state is the servant of all, not the few; that as a medical profession we could not oppose a law which in its operation would result in betterment of mankind even if it should interfere with our system of practice. We feel equally responsible that no legislation shall be enacted which, working hardship on the medical profession, shall, at the time, result in a system under which the public is not benefited but possibly harmed. We have always felt that the present system of practice built up during the ages has beneficial methods, aims,

* Address of the President-Elect presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept., 1931.

and purposes which must be preserved, and therefore we feel that a system of medicine in which the physician is the employee of the State and in which his relation to his profession and the patient is through an intermediary, is fundamentally wrong and almost certain to result in harm to both the profession and the public. Such a system therefore should be opposed and courageously fought in the public interest.

Jefferson pointed out that in addition to life, liberty and political equality, the pursuit of happiness is a state to which all people are entitled and which fits into the divine scheme of things. What shall we consider as conditional to the pursuit of happiness? As we analyze social life in this twentieth century I think we are forced to the conclusion that a very large percentage of our people, possibly as much as 90%, go through life handicapped by anxiety, fear and worry which are economic in their origin. The removal of this fear by securing to the masses economic security, seems to me the next step in human progress, and sociologists have long thought and taught that in the present state of society this end could be secured by insurance against sickness, accident, invalidity, maternal disability, old age, and unemployment. We are particularly interested in the first item. Statistics show that it is probably most important. Poverty is a disgrace in modern society not necessarily to the poverty stricken but to the social body which tolerates it, and sickness according to Professor Lapp is responsible for 30% or more of poverty. This is produced in two ways: by the direct cost of illness, and by loss of earning power.

Tremendous consequences followed upon the observation of Watt that the steam in the kettle lifts the cover. Out of that observation came the steam engine and the development of this machine age in which we live. Economic problems in the modern sense did not exist previous to that time. In fact in 1813 Adam Smith stated that there could be no problem of production or distribution because production was to population as one to one, but within another fifty years production was to population as twelve to one, and a half century later production is to population as twenty to one and now the problem of both production and distribution becomes very serious. Unfortunately our industrial leadership, while probably of higher quality and character than our political leadership, has devoted all of its attention to the one phase of the problem, namely production, and has neglected the concomitant phase of distribution until not only in America but everywhere in the world, production has so enormously outstripped buying power that our economic life and consequently our social life are in a chaotic state. Of this attitude, Morris Leeds, President of the Leeds-Northrop Company, states "It seems to me that it is not too strong a word to characterize the resulting situation as industrial stupidity".

The acuteness and strain of this problem were felt much earlier in Europe than in America. The advent of machinery and the concomitant reduction in number of laborers, resulted in unemployment, and unwise distribution resulted in unrest among the masses. This movement in the early eighties in Germany under the leadership of LaSalle caused Bismark, in an attempt to stay and appease the rising indignation of the lower classes, to institute the first social legislation in the form of social health insurance. This was followed in a few years by other countries of the continent, then in 1911 by England, since the War by France, Italy, and Russia, so that now it is safe to state that a large proportion of the laboring people of Europe are under socialized medicine. Probably 100,000,000 workers and their dependents come under this classification.

DISRAELI'S PRONOUNCEMENT

From the point of view of statecraft let it be said that Disraeli early enunciated that the first duty of a statesman was to conserve the public health, the vital resources of the nation, realizing that natural resources and capital must fail if there is a diminishing birthrate or if the health of the people is undermined. Cognizant of this, early in his second administration President Roosevelt appointed a Committee of 100 to study the problem of conservation of the vital re-

sources of America. I can not go into the details of the report which was submitted by Irving Fisher of Yale as Chairman. Suffice it to state that they concluded that there is in America today a waste in value exceeding three billions annually because the knowledge possessed by the medical profession is not available and is not employed by the people of the nation. The contention is that economic conditions are to a considerable degree responsible for this failure. Olin West, Secretary of the American Medical Association, states that the greatest problem before the medical profession today is to make available to all the people all that is best of medical service at a price commensurate with the ability of the patient to pay. In his address to the State Medical Society made in Madison in 1927, President Glenn Frank stated that unless the medical profession develops the statecraft within its own ranks to solve this problem, the politicians will do it for them.

Arthur Dean Bevan in an address before the Council of Medical Education of the American Medical Association in 1914 states, "Medicine is rapidly becoming a function of the state. It will mean state control and state support for public health, for medical licensure, for medical education, for medical research and to an increasing extent the medical care of the helpless . . . and when we have educated the people we will have no difficulty in securing the necessary laws, machinery and funds to make medicine in the best sense a great function of the state . . . If the profession in this country is farsighted it will recognize these coming events and direct them wisely."

John A. Lapp in "Health Insurance as a Means of Providing Medical Care" states, "If group organization fails, the alternative is state medicine. There are ample signs of this alternative. Step by step free medicine has been encroaching upon medical practice. Hospitals, dispensaries, clinics, school hygiene, industrial medicine and public health work are all encroaching upon the field of the physician. A smaller and smaller proportion of the aggregate of medical service is being given on the old basis. Probably half the medical care in the leading cities of this country is now provided outside of the private practice of physicians."

Evans Clark, Director of the 20th Century Fund, Boston, writes in the Atlantic Monthly, "Never has there been such acute public dissatisfaction with the organization of medical service as there is at present. In Europe the drift is toward state medicine. In this country, too, there is a definite set of opinion in that direction. Most American doctors look upon that solution with dismay. State medicine is their special bête noire."

PRESENT SHADOWS

Thus from political and social aspects, the coming event is casting its shadow before, but the problem also has an economic aspect. The United States Department of Labor states that the minimum living wage on the American standard should be at least $1250, still there is a large group, about 20% of our laboring people, who are in lower income brackets. How shall they pay? Well, of course, they do not pay. They are the recipients of free service from one source or another, usually from the physician. Hence from the economic point of view some system of distribution of medical service must be found that will make it possible for the layman to avail himself of the service without pauperizing him and without denying to the profession and the hospital a just return for the service. Does the public want such a service? I have been following for a period of about two years articles that have been appearing in the lay and professional press which indicate the public attitude in this matter. The American Medical Association has recently published a resume of 167 such essays. All of these written by laymen and a very large number of them written by physicians favored some form of social medicine.

The American Federation of Labor has placed social medicine as the first item of its legislative program, and if we had not been in the midst of a business depression which has made unemployment an even greater problem, I feel certain that we should have seen the introduction of such legislation during the past two years. In eight states bills have been presented providing for social

medicine. Dr. Harper states on very good authority that both candidates for governor on the Republican ticket were approached in the last campaign with the request to put into their platforms a plank promising legislation looking to social medicine. It is evident that large groups of laborers desire social medicine.

What of the industrial leaders? As you know, many of them are offering to their employees a socialized medical service of one type or another and by this I do not mean a service in conjunction with relief of injuries or accidents of employment, but for illnesses of the laborer and often members of his family.

Certainly the great insurance companies of the country have been interested, probably not more from a humanitarian point of view than from the point of view of profits. The Metropolitan Life Insurance Company expends $1,000,000 a year for nursing service, thereby saving $3,500,000 in death premiums. There is a considerable group of thinking men and women in America today looking forward to the enactment of law under which medical practice will be socialized to certain classes of our people.

What advantages would accrue to the masses through the establishment of such a system? If it were an adequate one, better facilities for diagnosis and treatment would be available so that we should secure earlier diagnosis, establish earlier treatment, effect more ready and permanent cure and thus avoid many chronic maladies. This would be especially true if hospitalization and the services of specialists were brought within the reach of those now unable to afford them.

The application and knowledge of preventive medicine would diminish and in some cases eradicate certain diseases and secure the saving of a proportionate amount of the three billions which the Committee of 100 states could be saved by this means. If socialization of medicine among employees would have the same effect in reducing incidence of illness as accident insurance has effected in reducing the number of accidents, then there should be a tremendous saving in industry from diminished loss of time from employment and diminished turnover in labor, and finally there would be eliminated from the minds of the less fortunate the fear, worry and anxiety associated with the economic and financial aspects of illness.

Physicians are opposed to state medicine. If that means a medical staff of government employees who, receiving a fixed sum per annum, would be assigned the care of a certain number of patients in all their illnesses, such a system to be dominated by a few political appointees whose only interest might be that they get as much service for as little expenditure as possible, I can well understand the opposition. Are they equally opposed to socialization of medicine, say under an insurance plan? Are physicians as a class opposed to the operation of the industrial accident insurance system now in use? I believe that in the insurance cases physicians are as free in their practice as with any other patients that come under their care, and moreover are assured remuneration for their services. They feel freer to send such patients to hospitals, to make use of x-ray and other methods of diagnosis, and probably render as good or better service to them as they afford to their own private clientele.

American physicians are concerned that the relationship existing between the patient and doctor will be very much disturbed. They fear that they may become the servants of a group of politicians and that as a consequence they will not be free in the conduct of their professional work and that possibly their remuneration would be reduced. They fear that the privacy and sacredness of the communications of the patient to his physician may be violated. The proponents of such a measure point out that under systems that have been tried no one of these objections is sustained and the patient does not suffer a violation of his confidences. The keystone of the whole structure is the family physician whose relation to his patient is the same under the system as obtains now in the private practice. So far as remuneration is concerned, the British and Latvian physicians report that their incomes have been materially increased under social medicine. It is not difficult to see why this should follow even if the rate per visit, office or home,

is somewhat reduced. The fact that many official and non-official bodies now invading the field of medicine would be eliminated would increase the work of the physicians and make available tremendous sums that could be expended for this purpose.

PRESENT EXTENSIONS

Let us look at some of the organizations now invading the field of medicine. Through the Sheppard-Towner Act maternal and infant welfare subsidized by the United States government and carried on by the State governments invades the field of medical practice. Venereal disease legislation has made it possible for any person afflicted with such an ailment to find free service in any of our large cities and in many of the smaller ones. Under State and local Boards of Health vaccination and immunization are carried on not by the family physician but by officers of organized society. Free dispensaries under voluntary organizations and in our medical schools take care of thousands of people annually. Great industries are gradually entering the field of medicine beginning possibly with diagnostic service which ultimately leads to treatment, hospitalization and complete care. Many fraternal bodies offer a free medical service. Accident work has been taken in considerable measure out of the hands of the family physician into the care of the panel physician. Tubercular patients are no longer treated by the family physician but have become the problem and care of organized units of society. Mental cases are wards of the State. In Iowa the county medical society employed by the county board renders medical service to the indigents of the county.

The United States government, through its Veterans' Bureaus and its Veterans' Relief, takes care of thousands of ex-soldiers; in fact has a potential clientele of something like 4,000,000 men. The service was limited to the ex-soldier having a service connected disability, but legislation introduced in the last Congress affords hospitalization and a complete medical care to all ex-service men for any disability irrespective of service connection. It is estimated that to carry out the provisions of this Act an additional 100,000 hospital beds and a very large staff of physicians to furnish medical and surgical care are required. The American Medical Association through its legislative committee proposes that in lieu of this, the ex-service man shall be given health insurance to cover any disability that may occur. Here is a measure at once socializing the medical service to a very large number of our citizens. It has been stated that there is probably $100,000,000 worth of free medical service rendered annually in the United States.

Plans which have been submitted by the British Medical Association to the Minister of Health in England advocate cessation of all such activities and incorporation of them into the general service under socialized medicine. This would materially improve the economic position of the physician especially as the work which he does among the indigents would be remunerative to him under such a system.

Another objection which the physicians have made is that they are compelled to keep records of their cases. This appears to me to be a great advantage. At the present time very few statistics appear in the literature that are obtained from records kept by private practitioners. Most statistics emanate from larger institutions, hospitals and clinics. The keeping of records by the family physician would very much improve both his knowledge and his practice.

WHAT SHALL THE SYSTEM BE?

From all the foregoing it is evident that almost everywhere in the world except in America this form of medical service is in operation. Twenty-three nations now have compulsory health insurance for people in the lower brackets of income, and 17 countries provide a voluntary system in which the wage earner may participate. In America alone of the great industrial nations, we are without such a system. From the point of view of economics, from the point of view of conservation of vital resources, and from the point of view of humanity, some system under which the medical profession can function much more perfectly would seem to be demanded. What shall the system be?

The problem has a financial side. How much will it cost? Who will pay the bill and who will supervise the expenditures? As to cost, it will be a great sum but Professor Lapp says, "Whatever the cost, it is worth it for who can determine the value of 100,000 lives saved or the extension of a decade of longevity to members of society?" Those nations which have such a system believe that it is profitable and not only continue their service but augment it from time to time extending its provisions from industrial to agricultural groups. It would certainly be less expensive than the waste at present sustained in loss of time from employment, by illness, by premature deaths, and invalidity which Irving Fisher places at more than three billions annually.

In addition to the actual annual expenditure of $750,000,000 for physicians' fees there is the useless and often worse than useless expenditure of about $300,000,000 for cult practitioners and $700,000,000 for patent medicines. Surely the cost of illness can be materially reduced and the physicians still receive as much and more for service if money is wisely spent.

It will not be difficult to secure the necessary funds. In those countries in which the system obtains they have encountered no difficulty and surely in America with all its resources we should have no problem from this source. Moreover, this need not concern us in the medical profession. If such a system is to be instituted, the legislation under which it shall be accomplished must provide the necessary funds for operation. Such fund is created in most countries of Europe by contributions from the recipient of the service if he is able to pay, by an assessment on industry, and a subsidy by the State. As to who should supervise the expenditure and distribution of the funds and be responsible for the service there should be no question. This is the function of the medical profession.

As to its operation I certainly do not feel competent to present any new plan. However, inasmuch as this form of social service has been in existence for nearly fifty years, some data is available on the basis of which conclusions may be drawn. The plan submitted by the British Medical Association to the Minister of Health, formulated after thirty years of study and about twenty years of practice, is worthy of very careful consideration. Under their scheme such medical service should be extended to every person in the community whose income is below or near the lower limit set as the minimum living standard, (for an American family, say $1500). They recommend that it should provide for all illnesses, that it should include wives and children and other dependents of such persons. They recommend what has at present not been obtained, that the service should be complete including hospitalization, nursing care, medicines and supplies, the service of specialists including dentists; that it should be compulsory for the class that comes within its scope and possibly a voluntary service extended to those in higher income brackets, on the basis of a proportionately larger contribution to the fund. It should be universal for the class and no industry, group, or society should operate such a service upon its own authority and under its own system. It should be administered by an extra political board much as the Workmen's Compensation Act is administered, and on this board there should be a considerable medical representation.

All physicians in any community who are in good standing in their profession and are found on trial to be competent, should be eligible to perform the work and not denied such privilege except after due trial and proper hearing. The patient should be given free choice of physician and the system be based on such family physician, thus will be maintained that intimate personal relationship which exists at present under our own system as between the physician and his patient. The payment of the physician should be on a fee basis.

Under these two considerations, the free choice of physician on the part of the patient, and the fee basis of payment, such competition as obtains under the present system would be continued and there could be no such disadvantage as would accrue to either patient or physician from a capitation system of payment. The fee should be ac-

cording to the present fee bills or schedules in use in most localities. This would result in much the same relationship as exists today under the Compensation Act as between the injured and his physician. In fact, if it were possible to extend the provisions of the Compensation Act so that it would include disability and care in illness, this might be a very happy solution of the problem.

Our colleagues in Canada are awake to the necessity of formulating definite plans, and the medical society of British Columbia has outlined and submitted to the legislative body its findings which are very like those of the British Medical Association, not for the purpose of securing such legislation but with the end in view of forestalling any unconsidered and hasty action which the politicians under more or less duress might enact into law.

RECOMMENDATION

This subject is presented to you from the point of view of a proponent of the plan, for we must meet the argument from that aspect. As a medical profession we do not advocate or encourage such a movement, rather we are opposed to it, but if we must accept some form of social medicine, then in the public interest the physician's advice should guide the statesmen as to the form it shall assume. The widespread dissatisfaction with the distribution of modern medical service led our National Secretary to state, "The great problem before us is to make all the service available to all the people at a price which they can meet." Social medicine is one solution to that problem.

It would seem advantageous to appoint a committee to investigate the whole matter of the economics of modern medical service, and report back to the next session of the State Medical Society its findings with recommendations which would incorporate our views on this subject, and which might be used as a guide to legislation should we have to face this problem in the State of Wisconsin.

Such action may seem premature, but if there is general dissatisfaction with the service as rendered, if social medicine is in successful operation in almost every industrial nation, if a very large group of thinking men and women of America and especially organized labor advocate it, if the number of articles that one sees in both lay and medical journals is indicative of public interest and dissatisfication with modern medical service, and if the next movement in social progress looking to human happiness requires economic assurance for those in the lower brackets of income, then, though seemingly premature and possibly radical, it is a problem which we must meet. As Dr. Bevan advises, "If we are farsighted we will recognize the coming events and direct them wisely", for failing to do so President Frank warns us the politicians will do it for us.

Infantile Paralysis*

By J. E. GONCE, Jr., M. D.
Madison

With the appearance of a fairly large number of cases of infantile paralysis in the state as early as the first part of July of this year, it is more than likely that a rather severe epidemic of this disease will occur before winter sets in. In past years it has been the rule for the number of cases to increase as the summer months go by until a maximum number is reached in September or October. Consequently it behooves every physician to be prepared to meet the situation, and it is my purpose in this paper to help in that preparation by a recital of some of the outstanding facts concerning the disease.

The chief points for the physician to keep in mind about infantile paralysis, as I see them, are—1. Communicability, 2. Early diagnosis, and 3. Early administration of convalescent serum.

The disease is unquestionably contagious. Although in many instances, especially in the sporadic cases in the winter, no history of contact may be obtained, enough ex-

* Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept. 1931.

perience, both clinical and experimental, has been had to establish the fact that the disease is definitely contagious. In fact, infantile paralysis is so contagious and so prevalent that the majority of persons become immunized either subclinically or through unrecognized attacks of the disease. That abortive forms and unrecognized symptoms do occur is shown by the fact that the blood serum of a certain proportion of individuals, not known to have passed through an attack of the disease, will neutralize the virus of infantile paralysis. In addition, an analysis of the age distribution of poliomyelitis in relation to concentration of population shows that the greater the density of population the earlier the age at which immunization takes place, thereby indicating dissemination of the virus by unrecognized cases and healthy carriers. The age distribution in general is 50% of all cases under 5 years of age, 80% under 10 years, 90% under 15 years and 95% under 20 years. Immunity therefore takes place in practically all persons by the age of 20 years, and one might, as does Aycock, consider the development of an attack of infantile paralysis as an accident in the development of immunity. During the past 10 years the average age of persons affected with infantile paralysis in Milwaukee was 5 years, whereas the average age in the rural districts of Wisconsin was 9 years. In other words the incidence of the disease was more evenly spread through the older age groups in the rural districts than in the city. This high incidence in the first half of childhood in the cities and the even spread into the second half in the rural communities very clearly indicates a widespread subclinical immunity which is accomplished with greater rapidity in urban than in rural population. Furthermore, the age distribution and the age incidence of infantile paralysis in relation to concentration of population are practically the same as with diphtheria which is unquestionably a contagious disease. These phenomena of age distribution and age incidence in relation to density of population being similar, it would appear that the mechanism involved is identical for the two diseases. It it a well known fact that the age distribution of diphtheria is largely determined by subclinical immunity. The similarity of the age distribution of poliomyelitis to that of diphtheria is therefore an evidence that immunity, largely subclinical, is likewise responsible for its (poliomyelitis) age distribution. These facts definitely indicate the very great contagiousness of infantile paralysis.

Although the actual causative agent of infantile paralysis has not yet been identified, many facts about it have been discovered. In 1909 Landsteiner and Popper transmitted the disease from man to monkey by the intraperitoneal injection of a small amount of an emulsion of the spinal cord of a child who had died of poliomyelitis. Later it was found that the disease could be transmitted to monkeys by intranasal implantations and intracerebral injections of emulsions of spinal cord from human beings or monkeys who had died of the disease. It was also soon discovered that when such an emulsion was combined with serum from a human being or monkey who had recovered from infantile paralysis, that the virus became neutralized or inactivated. That the virus is filterable was also discovered early.

The virus has been demonstrated in the brain, cord, medulla, basal ganglia, sympathetic ganglia, nasal and pharyngeal mucosa, tonsils and lymph nodes, but its presence in human spinal fluid and blood can not be detected. Under ordinary circumstances it is not found in the mucosa after the tenth day of the disease, but in exceptional cases persists there for months.

Many other facts of interest concerning the resistance of the virus to various agents have been discovered. It is not destroyed by drying, by freezing, or by weak chemicals such as those commonly used for spraying into the nose and throat. It may persist in water and milk for more than 30 days. It is killed by exposure to 50° C. (122° F.) for 30 minutes and is therefore destroyed by pasteurization. It is also killed by exposure to sunlight and strong disinfectants.

As to the manner of transmission, both experimental and clinical experience indicate that the virus is communicated by secretions of the mucous membranes of the nose and throat and that entrance into the body is by way of the nasopharyngeal mucous mem-

branes. Although several isolated outbreaks of the disease have been traced to infected milk supplies, all other information at hand indicates that the infection is conveyed by acute cases of the disease, by abortive and undiagnosed cases, by convalescents, and by healthy contact carriers.

The incubation period probably varies from 6 to 20 days averaging 7 to 14 days. The incubation period of the experimental disease in monkeys due to intranasal inoculation is fairly constant at 10 to 12 days.

EARLY DIAGNOSIS

Early diagnosis of poliomyelitis is not always a simple matter, especially as the clinical manifestations are subject to considerable variation depending upon the type of the disease. In the past it has been the custom to classify the types of poliomyelitis according to the anatomical site of involvement or according to the courses the disease may take. In as much as the disease is apparently at first a general systemic infection which may or may not go on to involvement of the central nervous system, a classification which is based on the possible courses the disease may take will perhaps furnish the clearest understanding of the disease. Now I say that the disease is at first a general systemic infection because in 10% of all accurately diagnosed cases of infantile paralysis there is a preliminary stage of general systemic involvement precedng, by several days, the signs of meningeal involvement. For example, a child is taken ill with fever and the signs of an upper respiratory infection or gastro-intestinal disturbance which last for 24 to 48 hours. This illness is presumably indicative of a general systemic infection. The child becomes free from symptoms but in 2 to 4 days he is again attacked by fever and the signs of meningeal irritation indicating invasion of the central nervous system. One to four days later paralysis may follow representing extension of the inflammation to motor nerve cells. It is believed that the disease may be stopped at any point in this development. Hence the rationale of the classification of types into abortive, nonparalytic and paralytic.

The abortive type corresponds to the stage of general systemic infection. The existence of this limited type of case is entirely presumptive but it fits in with the theory that this type occurs very frequently and is responsible for the immunization of great numbers of people.

The non-paralytic type corresponds to the pre-paralytic stage of the paralytic type and the symptoms in the two are identical except that in the non-paralytic type the disease stops short of paralysis. In this type evidences appear of involvement of the central nervous system. In 90% of the cases this stage is not preceded by the signs of general systemic involvement. In the 10% of cases where the preliminary stage has been present the term "dromedary" type has been used. However, with or without preliminary involvement the onset of the symptoms of this new stage is usually rather sudden. Fever, headache, and vomiting are customarily the first symptoms. The temperature ordinarily rises to around 101°F. but may, in some cases, reach 104°. Headache is sometimes very distressing and may be general or frontal in situation. Vomiting is frequently present at the onset but is not persistent. Anorexia often continues throughout the course of the acute manifestations. Constipation is rather more common than diarrhea. Dizziness, irritability when awake, drowsiness when unmolested and pains in the back and limbs are apt to appear soon after the onset. Hyperesthesia is very common, and the patient is particularly tender along the spine and in the legs. Sometimes there is photophobia, or excessive sweating, or retention of urine. There may be coarse tremors or convulsive twitchings of various groups of muscles. Delirium is apt to appear in the cases having severe involvement. The pharynx is usually congested to a moderate extent. The pulse rate is usually rapid and often out of proportion to the fever. In appearance the patient looks and acts sicker than the degree of fever would indicate.

Now is the time at which the diagnosis should be made in order to accomplish the most good with convalescent serum. However, in order to make an accurate diagnosis a most careful physical examination for evidence of central nervous system involvement

is necessary. Stiffness of the neck and spine is always present but is usually slight and never so marked as in tuberculous meningitis or cerebrospinal meningitis. It is often so slight as to be missed by the examiner unless specifically looked for. Its detection is often impossible with the child in the supine position by the ordinary method of raising the head from the pillow. Instead, it is necessary to hold the child in a comfortable position and ask him to kiss his knee, whereupon, when the sign is positive, the child after commencing the action refuses to complete it because of pain in the back. Another method of eliciting this sign is that described by Amoss. When the child is placed in a sitting posture upon a firm surface, such as a table or chair, the position assumed is that of tripod, the child conveying part of the weight of the body through the arms in order to ease the pain in the back. The presence or absence of this sign may also be demonstrated by raising the child from the recumbent position with the examiner's hands placed under the buttocks and shoulders. When the sign is positive, the child will not hold his head in the horizontal plane with the body but instead, on account of pain, will permit it to fall back.

The knee jerks are usually increased at this time and may be unequal. Kernig's sign is often negative but may be positive, particularly in those cases showing more than usual meningeal involvement. The blood count ordinarily shows an increase in the white blood cells to around 15,000 and an increase in polymorphonuclear cells to 80 to 90 per cent.

In the presence of symptoms and signs, such as these, the pre-paralytic stage of poliomyelitis should at least be suspected but the absolute diagnosis depends upon the spinal fluid findings. The spinal fluid in poliomyelitis may or may not show an increase in pressure. The fluid may be clear where the cell count is still low, or hazy, or have a "ground glass" where the cell count is higher. The number of cells averages from 200 to 300, but may vary from 20 to 1200 or more. Care must be taken to examine a fresh specimen of spinal fluid in as much as the cells tend to dissolve in an hour or so. Albumin and globulin are usually moderately increased. The amount of sugar is the same as in normal fluid or may be in excess. The gold sol curve is characteristically 1122100000.

The disease may stop here or it may go on into the paralytic stage. That it may stop at this point has been proved by Neal who was able to transmit the disease to monkeys with nasal washings from just such cases. However, in the pre-paralytic stage it is impossible to predict from the clinical symptoms, the physical findings, or the spinal fluid changes whether the case will escape without paralysis or become paralyzed, or even go on to a fatal termination.

The paralytic type may be divided into 3 types—the ataxic, the upper motor neurone involvement, and the lower motor neurone involvement.

The ataxic type is very rare in occurrence. The motor nerve cells are not involved but there is ataxia, nystagmus, and lack of coordination. The signs come from involvement of the cerebellum, Clarke's column, and the intervertebral ganglia.

The upper motor neurone involvement resulting in spastic paralysis is also very rare in occurrence.

The lower motor neurone involvement resulting in flaccid paralysis is, of course, the most common form. This form may again be divided into the spinal cases, bulbar cases, and combinations of spinal and bulbar involvement.

Paralysis usually appears during the first four or five days of the disease and in many cases comes on during the second day. In some uncommon instances the paralysis appears within a few hours of the onset and is preceded merely by lassitude and fatigue. Once the paralysis occurs it usually reaches a maximum within a few hours of its onset, but in some instances it appears to spread up the body, eventually involving the muscles of respiration and causing death from asphyxia. In the average case, with the appearance of paralysis, the fever gradually returns to normal in 4 to 6 days. Pain in the back and extremities is apt to continue for several days. Following the wave of appearance of paralysis, recovery begins to set in,

and evidences of improvement may usually be found within two weeks; mild cases, indeed, may clear up within one week.

CONVALESCENT SERUM

Although convalescent serum is not specific for poliomyelitis in the sense that diphtheria antitoxin is for diphtheria and although the case for convalescent serum has not been proved conclusively, there is evidence to show that when given in the preparalytic stage it does exert a beneficial influence. For example, by the scale used by the Harvard Infantile Paralysis Commission the grade of paralysis was 63.6 in the untreated cases as against 19 for the paralyzed treated cases. It is in a way strange that the results from treatment with convalescent serum are not better than they are because the reasons for its use are certainly well grounded. It is well known that an attack of poliomyelitis just as is the case with measles, apparently confers a lasting immunity to the disease. The serum of convalescents should then be expected to contain virucidal properties. That it does contain virucidal properties is shown by the fact that when mixed with the virus it is impossible to transmit the disease to monkeys by injections of the mixture. Furthermore, when convalescent serum is given alone to the monkey it is impossible to produce the disease for a matter of several days even by intracerebral injection of the virus alone. The imperfect results from convalescent serum may be due to insufficient dosage, and if it were possible to concentrate convalescent serum as readily as diphtheria antitoxin, better results might be obtained from its use.

In as much as convalescent serum does exert a beneficial influence when given in the pre-paralytic stage, and in as much as there is no other form of treatment which is scientifically as well established, convalescent serum offers the most hope as a method of treatment. I would stress the importance, however, of the need for its being administered in the pre-paralytic stage. Later when paralysis has occurred nothing can repair the injured nerve cells, although it is possible that convalescent serum might prevent further paralysis.

As to the route of administration it would seem that in as much as the convalescent serum must reach the cerebrospinal fluid in order to do the most good, it should be given directly into the spinal canal. Experimentally, monkeys can be protected from ordinary fatal amounts of virus by means of small injections of serum intraspinally. However, it has been shown that the serum given intravenously or intramuscularly is able to gain entrance into the cerebrospinal fluid because of the alteration of the meningeal-choroid plexus complex defense brought about by the virus. And as a matter of fact, several clinicians have reported satisfactory results by treatment with intramuscular injections of serum. Consequently it would seem desirable in the treatment of infantile paralysis in the pre-paralytic stage to complement the intraspinal administration with an intravenous or intramuscular injection of serum. By clinical experience it has been determined that an effective dose consists of 10–30 cc. of serum intraspinally and an amount intravenously or intramuscularly to make the total come to 50–60 cc. Many clinicians, however, depend entirely upon the intravenous and intramuscular routes of injection.

In the actual intraspinal injection of the serum it is most important that the serum be warmed to body temperature (not beyond because of the danger of coagulation), that it be given very slowly (not more than 1 cc. per minute) and that an amount of serum, less by several cc. than the amount of spinal fluid withdrawn, be given. It is, of course, also most important that a serum containing no additional matter other than a proper preservative or better yet no preservative at all be used. If a severe reaction should occur the immediate withdrawal of the injected material will greatly lessen the reaction and in the very severe reactions save the patient's life. These very severe immediate reactions are most unusual but have been known to happen, and it consequently is a good practice to leave the lumbar puncture needle in place for a few minutes after the injection of the serum has been completed.

Another very important consideration in respect to serum therapy of infantile paralysis is the necessity for the intraspinal, intravenous, or intramuscular administration of the serum at the time of the first lumbar puncture. Both experimental and clinical experiences have shown that lumbar puncture lowers the resistance of the meningeal-choroid plexus complex defense to the extent that the invasion of the cerebrospinal fluid and nervous tissue by the virus is greatly facilitated and accelerated. The greater the delay then between lumbar puncture and serum administration the less the possibility of neutralization of the virus by the serum. In other words, lumbar puncture for diagnostic purposes is not justified unless the serum is right at hand for immediate injection should the spinal fluid finding be positive for poliomyelitis. This means, of course, that when the spinal route of injection is going to be used, the spinal fluid must be examined while the needle is still in place.

PROPHYLAXIS

A final point for consideration is concerned with prophylaxis of infantile paralysis. Every child definitely exposed to an active case during the first three weeks of the disease should be afforded protection by the subcutaneous or intramuscular injection of either convalescent serum or whole blood from both parents. Parents are presumably immune to infantile paralysis, but in order to be sure of obtaining active immune substance it is better to use the blood from both parents rather than from a single parent. Ten to twenty cc. of convalescent serum or 15–20 cc. of blood from each parent is probably a sufficient amount to afford the necessary protection if administered within a few days after exposure.

Multiple Sarcoma of the Lungs, Secondary to Teratoma of the Testicle; Report of Case

By S. D. GREENWOOD, M. D.
Neenah

The case was first seen by Doctor George H. Williamson of Neenah. The patient, age 37, a merchant, married, was seen in January. E. H., the patient, complained of dizziness, nausea and vomiting, constipation with clay colored, pasty stools. His skin appeared rather "muddy." The patient's condition was diagnosed as cholangeitis and the duration of the illness was only a few days. The symptoms were promptly relieved with rest, medication and diet. The patient admitted loss of weight. Carious teeth and questionable tonsils were observed and advice given to have these corrected.

On March 10th, E. H. returned for further observation after having the carious teeth removed. The patient's appearance was not improved and his weight remained the same. Laboratory examinations showed the blood smear to be negative, hemoglobin 70, and the urinalysis normal. The blood pressure reading was 130/90. Chest examination was negative. The patient had developed an unproductive, irritating cough that disturbed his rest.

The patient was next seen on April 4th after having had a tonsillectomy. He complained of loss of weight, indifferent appetite, difficulty in breathing and a cough, but the cough was unproductive. Laboratory findings corresponded with previous examination. Temperature was normal. Clubbing of fingers was noticed. Examination of mouth, throat and neck was negative. Von Pirquet skin test was negative. On examination of chest the left border of heart was at nipple line and the heart tones were normal. When the lungs were examined there was increased vesicular breathing in outer two-thirds of chest, front, back and both sides. There were no rales and the bronchial sounds were increased. Deep percussion showed dullness extending well away from the sternum and along both sides of sternum from manubrium to 5th rib. Free expansion was somewhat forced and respiration was slightly labored. The abdomen and pelvis were negative. There were no hemorrhoids. There was a small tumor of the right testicle extending above epididymis, not tender,

rather hard and incompressible. Patient said it had been there a "long time and never hurt." He did not believe it had changed in size. Lower extremities were normal. X-rays were insisted upon.

On April 26th the roentgenologist's report revealed the presence of five tumors, two in the left lung and three in the right. On the left side one was seen in about the middle of the upper lobe; it was round in form, of marked density, with well defined margins, about 5cm. in diameter and was isolated. In the midportion of the lower lobe, just above the level of the dome of the diaphragm another tumor of like size but lesser density was found. On the right side a larger ovoid tumor measuring about 6 x 10 cm. was seen with its inner border merging into the hilum shadows of the upper lobe. In the peripheral portion of the lower part of the upper lobe another tumor of slight density was seen, its inner margin overlapping the first. Its borders were well defined and it was about 6 cm. in diameter. A third faint shadow a little lower and nearer the periphery was also found. (See Fig. 1).

Re-examination a month later showed material increase in all tumors. (See Fig. 2). After the lapse of another month skiagrams were again taken and at this time much further increase in size had occurred and the upper right lung had become largely replaced by tumor tissue. (See Fig. 3). Unfortunately, for the purpose of illustration the tumor in the left lung at the phrenic border, while very distinct in the original skiagram, did not print well.

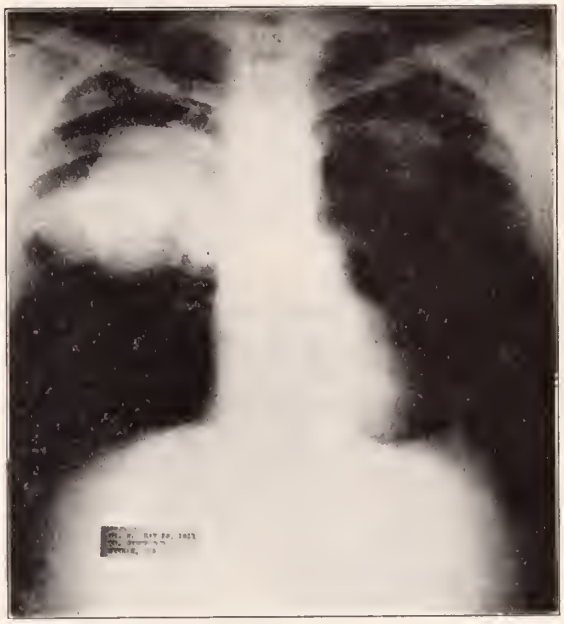

Fig. 2.

With loss of weight, presence of testicular new growth, clubbing of fingers, dyspnea and physical signs plus the x-ray pictures, the

Fig. 1.

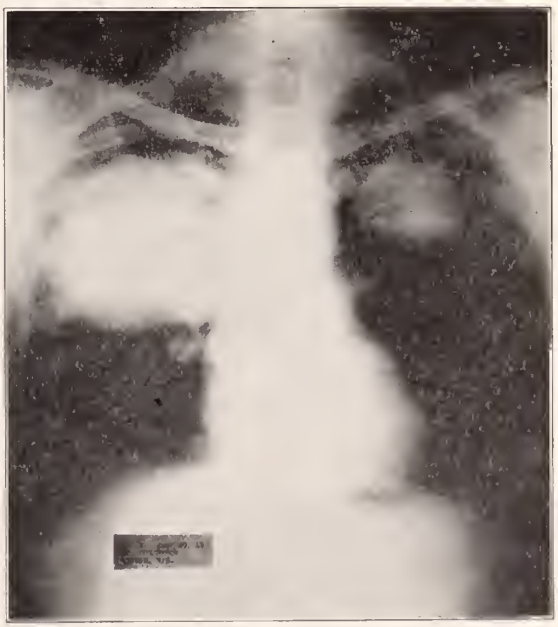

Fig. 3.

diagnosis of secondary sarcomata of the mediastinum was made. The patient developed an afternoon temperature. From that time on the patient failed steadily and emaciation increased. The cough, dyspnoea and cervical and facial cyanosis became more pronounced and the patient expired on December 15th.

This case is of interest because the primary growth was apparently almost insignificant, at least the patient had ignored it, and further because of the difficulty in the way of making an early positive diagnosis except by the use of x-ray. The possibility of using x-ray therapy was discussed, but because of poor prognosis the treatment was not given.

THE JOURNAL CLINIC

Spinal Anesthesia; New Type of Needle Used

By W. C. FRENZEL, M. D.
and
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Wausau

With the advent of spinal anesthesia, the necessity for an accurate quick puncture of the canal became imperative in order to make this type of anesthesia practical.

While the Pitkin needle is a great improvement over the older type of needle in so far as it does less damage to the dura and thus prevents post spinal sequellae of headache and nausea, it still has a number of important disadvantages. The danger of breaking the needle in the canal is always present and with this factor in mind we decided to determine causes, outside of the personal factor involved that make a spinal puncture difficult. Observation showed us that despite the fact that the steel needle used was sharp, marked resistance of the tissue to the passage of the needle was noted even after the skin was punctured. This had a tendency to detract from the accuracy of the puncture as the direction of the needle was often shifted in overcoming this resistance.

In order to remedy this resistance of the tissues, a platinum iridium needle of the Pitkin type was made to order. This needle has been used in a series of cases with most gratifying results.

The resistance of the body tissues to the passage of this needle is only about one-fifth as great as that of the steel needle. Hence, more accurate puncture with less trauma is possible. Another decided advantage over the steel needle is lessened danger of breaking the needle off in the canal as the metal is very ductile and bends readily without fracture. Finally a puncture can be made with decidedly less pain to the patient as shown in our series of cases in which the puncture was completed without the knowledge of the patient.

SUMMARY

A needle for spinal puncture is presented which has advantages over the steel needle in so far as it offers less resistance to the tissues, makes for better and quicker punctures and offers practically no danger for fractures in the canal.

Agranulocytic Angina: Report of Three Cases*

By MARIE L. CARNS, M. D.
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The condition subsequently known as agranulocytic angina was probably first referred to in 1907 by Turk[1] who called attention to the low granulocyte count in some cases of severe sepsis. Seemingly nothing further was reported on this subject until 1922 when Schultz[2] described a number of cases characterized by almost complete ab-

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sence of granular cells from the blood stream associated with certain pathologic conditions and symptoms. These he considered to constitute a clinical syndrome and suggested the name agranulocytosis. In 1923, Freidemann[3] named this group of cases agranulocytic angina. Although this term has been rather widely accepted, confusion still exists since it has been used by some as synonymous with agranulocytosis and by others for differentiation.[4] To date about one hundred and fifty cases of so-called agranulocytic angina have been reported. These cases presented a wide variation in symptomatology, physical and laboratory findings, and pathological changes.

From a review of the literature the outstanding characteristics of this syndrome may be briefly stated as follows:

1. The majority of the cases occur in women, usually in middle age.
2. The onset is usually acute, but occasionally has been noted to occur in persons who have been ill for some time with a chronic disease.
3. At the onset of the disease chills, fever, and malaise are found. Profound prostration is common.
4. The blood picture is one of marked leucopenia with a marked diminution or an absence of polymorphonuclear leucocytes. The lymphocytes are often relatively increased up to 100%.
5. Necrotic or ulcerative processes have been observed almost constantly in the oral cavity.
6. Regional lymph node enlargement is usually found.
7. The spleen and liver have occasionally been found to be enlarged. Jaundice was present in 58% of the cases reported by Kastlin.[5]
8. A variety of organisms has been recovered from the oral lesions, including Vincent's spirilla and fusiform bacilli, Klebs-Loeffler bacilli, pneumococci and steptococci of various types.
9. In a great majority of cases, blood cultures have been sterile.
10. The disease is of relatively short duration, lasting from a few days to a few weeks. The mortality is high, although a number of cases with recovery have been reported. (Harkins has collected reports of about 150 cases from the literature with a mortality of 82%.[6])

At the present time there seems to be considerable confusion as to whether we are dealing with a new disease entity, with an old disease not recognized or reported prior to Schultz' description in 1922, or rather with an indefinite group of cases in which the individual's bone marrow reacts differently to certain etiological agents than does that of most persons. It seems as though one way to clarify the existing confusion is the reporting of all cases which have seemed to fall into this symptom complex in order that all possible information available on the subject may be collected. For this reason, the case reports of three patients so diagnosed at the Wisconsin General Hospital are submitted.

CASE REPORTS

E. E. E., a white female, aged 59 years, was admitted on February 18, 1929, following a fall three hours earlier.

Physical examination revealed a deep laceration of the scalp in the left occipito-parietal region and a fracture of the left patella. There were no other pertinent positive findings.

The scalp was sutured and a cast was applied to the left thigh and leg. Her blood count on admission showed 58% hemoglobin with 4,170,000 red blood cells and 13,500 white blood cells with 76% polymorphonuclear neutrophiles. 1% eosinophiles, and 23% lymphocytes. The laboratory findings were otherwise negative, except for a blood sugar of 164 mgs. (The patient had previously been diagnosed as having a mild diabetes mellitus which could be entirely controlled by dietary measures).

The patient's course was satisfactory until March 6, 1929, at which time she had an elevation of temperature to 99.6 degrees F. She had no subjective symptoms at this time. Her white blood count and differential on March 1st (the last blood examination prior to rise of temperature) was practically the same as on admission. The temperature continued to be elevated with considerable diurnal variation and on March 9th reached 100.8 degrees F. On this day the white blood cell count was 4,800 with 64% polymorphonuclear neutrophiles, 35% lymphocytes and 1% basophiles.

The patient complained of a slight cough and gen-

eralized aching, but there is no record of subjective or objective abnormalities in the throat. On March 15th there were 3,000 white blood cells with 93% polymorphonuclear neutrophiles and 7% lymphocytes and on March 16th there were 1,850 white blood cells with 100% small lymphocytes. At this time the temperature was ranging between 98.6 and 100 degrees, and the patient had no complaints other than slight malaise. On March 18th the throat was noted to be slightly reddened and the patient complained of a painful gland in the right cervical region. Daily blood counts from this date on showed complete absence of granular leucocytes until March 22nd (a total of six days). The lowest total white blood cell count was 950 on March 20th. Her most marked febrile reaction occurred during this interval, the peak of fever reaching 102.6 degrees. The patient complained of sore throat and painful cervical glands on the right throughout this same interval. Examination showed a diffuse congestion of the mucous membrane of the throat with some oedema of the pillars and uvula, but no ulcerations. There was some inflammation of the mucous membrane of the mouth. Cultures from the throat and mouth were negative for Vincent's spirilla and fusiform bacilli and B. diphtheriae. The blood gave negative agglutination tests to B. typhosus, B. para-typhosus, B. abortus, and B. tularense. Blood cultures were negative. The blood showed 2% polymorphonuclear neutrophiles on March 22nd and there was a progressive increase in both total leucocytes and in neutrophiles until the patient was discharged on April 6, 1929, at which time there were 16,100 white blood cells with 72% polymorphonuclear neutrophiles and 28% lymphocytes. Subjective and objective improvement of the throat condition was coincident with the return of granular leucocytes.

On May 11, 1929, the patient returned for further observation. At this time her total white blood cell count was 15,700 with 65% polymorphonuclear neutrophiles and 35% small lymphocytes.

The very striking point in this case is the reduction of granulocytes within 24 hours from 93% of white blood cells to a complete absence of granulocytes with a total white blood cell count of 1,850. Complete absence of granulocytes in the blood stream preceded by two days the onset of throat symptoms. This patient, after having had a complete absence of granulocytes in the blood for six days, has remained well up to the present time (one year and ten months).

SECOND CASE

J. M. B., a white male, aged 62 years, was admitted on March 30, 1928, complaining of lameness and stiffness. He dated the onset of his present illness as December 1, 1927, at which time he first noted muscle pain in both lower extremities. He stated that he believed the joints not to be involved. On February 1, 1928, a similar condition developed in both upper extremities. Other symptoms of which he complained included intermittent fever, frontal headaches associated with vertigo and of many years' duration, impaired hearing on the left, recent oedema of the ankles, a chill two weeks previously and moderate costiveness. His past medical history included the usual infectious diseases of childhood, pneumonia in 1900, "lumbago" in 1923, and cystitis in 1926. The social and family histories were irrelevant.

Physical examination showed the patient to be well developed and nourished although he showed evidences of considerable weight loss. Positive findings included irregular pupils, cardiac enlargement to the left with slight widening of the aortic arch, loud systolic murmur at the apex, blood pressure 130/90, radial vessels thickened and beaded, liver edge palpable, tenderness in the muscles of the upper and lower extremities and slight limitation of movement in the shoulder, elbow and wrist joints. There was no cervical adenopathy and the spleen was not palpable.

Significant laboratory findings included a trace of albumen and occasional hyaline casts in the urine, left ventricular predominance in the electrocardiogram, and a blood count on March 31, 1928, showing 50% hemoglobin, 4,020,000 red blood cells, 2,100 white blood cells with 6% polymorphonuclear neutrophiles, and 94% lymphocytes.

On April 2nd (three days after admission) the patient complained of a very sore throat and had an afternoon temperature of 102.4 degrees. He continued to have an elevation of temperature from this time until his death, with considerable diurnal variation ranging from 99.4 to 104.2 degrees. He continued to complain of severe sore throat and on the morning of April 5th developed a cough with hemoptysis. His physical signs at the base of the left lung posteriorly were interpreted as pulmonary infarct while further pulmonary changes just before death were diagnosed as bilateral bronchopneumonia. The blood count on April 3, 1928, showed 1,450 white blood cells with 98% lymphocytes and 2% mononuclears. On April 4th the total white blood count was 1,600 with 100% lymphocytes and on April 5th white blood cells numbered 800 with 100% lymphocytes.

The patient expired on April 6th. Permission for post mortem examination could not be obtained.

The first blood count on this patient was taken on March 31st. This shows that a marked diminution of granulocytes in the blood stream (6% of 2,100 white blood cells) was present in this case as in the preceding one, at least two days before the development of the throat infection.

THIRD CASE

A. S., a white female, aged 34 years, was admitted on July 17, 1929, with a chief complaint of weak-

ness. She dated the onset of the present illness to 1920, at which time she developed a diarrhoea which had persisted at short intervals up to the present. The stools had contained blood at times. She also complained of severe headaches, vertigo, anorexia, backache and abdominal cramps. Her symptoms had been more marked following her last pregnancy in 1926, and during this time she had also had attacks of chills several times weekly. Her past medical history included diphtheria in childhood, and influenza followed by pneumonia in 1918. Her social and family histories were unimportant.

Physical examination showed undernourishment, pallor, marked oral sepsis, hypertrophied, cryptic and injected tonsils, generalized abdominal tenderness, palpable liver, moderate vaginal discharge and a third degree retroversion of the uterus. Proctoscopic examination revealed the presence of an old rectal fissure. Temperature on admission was 100.2 degrees F., pulse 90 and respirations 22.

Laboratory examinations on admission showed a urine without pathologic findings. a blood count with 50% hemoglobin, 4,260,000 red blood cells and 5,850 white blood cells with 92% polymorphonuclear neutrophiles and 8% lymphocytes. Gastric analysis showed a total acid of 16 degrees, no free acid, positive lactic acid and occult blood. The blood Wassermann was negative and blood chemistry determinations were within normal limits. Five stool examinations were reported as negative to tubercle bacilli, ova, parasites, and B. typhosus, with B. coli and streptococci the predominating organisms. The basal metabolic rate was +6. Intravenous phenolsulphonphthalein test showed a total return of the dye of 70%. Vaginal, cervical and urethral smears were negative for gonococci. Nose and throat cultures were negative for Klebs-Loeffler bacilli. Blood agglutination tests were reported suspicious for B. typhosus and negative for B. para-typhosus, Brucella abortus and B. tularense on three occasions. Fluoroscopic examination and x-ray studies of the stomach showed no pathology; the colon was of a redundant and atonic type.

On July 26, 1929, the blood count showed 6,350 white blood cells with 36% polymorphonuclear neutrophiles and 64% small lymphocytes and on July 29th a total of 1,700 white blood cells with 100% small lymphocytes. Coincident with the first noted complete disappearance of granular leucocytes a marked angina and gingivitis were observed. The tonsils were enlarged and injected with a white exudate in the crypts. The cervical, axillary and right epitrochlear lymph nodes were moderately enlarged and the spleen was easily palpable. The patient had had a slight irregular fever since admission, but her temperature rose on July 28th to 100.2 degrees and remained between 100 and 105 degrees until her death on August 11th. Two blood cultures (on July 31st and August 1st) were negative. Throat cultures on August 3rd showed fusiform bacilli and Vincent's spirilla. The patient became progressively worse and ulcerations of the mucous membranes of the mouth were marked. The blood count continued to show a complete absence of granular leucocytes until death with a terminal total leucocyte count of 1,000 with 100% small lymphocytes. She was transfused on August 8th following which she suffered quite a marked reaction with a macular eruption over the abdomen. On August 11th rales were present in both lung bases and the patient expired on that date 13 days after the complete disappearance of granular leucocytes in the blood.

Permission for autopsy could not be obtained.

It is interesting to note that on admission this patient had reacted with a relative polymorphonuclear increase (to 92%) subsequently showing a relative and absolute decrease of polymorphonuclear cells down to their complete disappearance. The marked angina and gingivitis were first noticed on the same day as the complete disappearance of the granulocytes, but unfortunately no blood count had been taken on the two days preceding this. The count taken three days previously had shown a relative lymphocytosis (64%). This patient lived 13 days without showing a granular leucocyte on any one of the daily examinations.

COMMENT

In two of these three cases, a marked diminution of the granulocytes in the blood stream was demonstrated two days before the onset of throat symptoms. This would lend support to the theory that the condition is primarily a failure of the hematopoietic system as regards its leucogenetic function, and that the anginal picture is secondary. It has been pointed out that E. Frank, in 1915, seven years before the publication of Schultz' article, described a similar condition under the name of panmyelophthisis, which is descriptive of this failure of the hematopoietic system and seems more closely to suggest the underlying pathology than does either the name agranulocytic angina or agranulocytosis.

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OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

EDITORIALS

THE NINETIETH ANNIVERSARY MEETING

RECENT meetings of our State Medical Society each have been outstanding in merit and accomplishments. We are impressed that this has been particularly true since the adoption of the new Constitution which provided that the Committee on Scientific Work should be composed of the appointee of the President acting as Chairman, and the past two Chairmen. This, we are convinced, has gone far to provide a continuity of programs without eliminating the new features that each succeeding chairman has inaugurated.

This year's meeting combined all the proven features of previous meetings with a program that presented the widest possible variety of subject matter. That it met with approval is evidenced by the splendid attendance from the first session on Wednesday morning to five-thirty on Friday afternoon.

Chairman Arthur Sullivan and his associates may well be happy in their accomplishments. It was the type of meeting that will go far in the development of Wisconsin medicine.

NEW CONCEPTIONS OF POLIOMYELITIS

A BULLETIN from the State Board of Health is just received calling attention to the probability of an increasing number of cases of this disease in widely scattered communities throughout the state.

It is exceedingly opportune that Burrows* has recently focused attention upon some features of this malady which are not so generally known. He speaks from a large pathological and clinical experience so that his observations deserve serious consideration.

He asks, "Is poliomyelitis a lymphatic disease?", then proceeds to show that it is. The intitial lesion is in the lymphatics, particularly of the gastro-intestinal tract. In fatal cases the Peyer's patches in the ileum are swollen. The lymphatics elsewhere are involved. The spinal cord lesions, the feature which gives to the disease its tragic side, are more or less accidental. If one wishes an analogy, he can consider scarlet fever where many cases will occur and only an occasional serious kidney complication will result.

Poliomyelitis is a widespread disease; it is always with us. Like the exanthemata, the number of cases rises and falls with the accession and recession of non-immune children in the population.

The majority of children are naturally immune to the disease. The symptoms are primarily gastro-intestinal and the mode of infection is probably by the gastro-intestinal

* Burrows, M. T., Arch. Int. Med., 48:33, 1931 (July)

route rather than by the respiratory route. Many cases are so mild that the child is ill only a day or two. Where there is a large child population, many cases will occur but the majority go unrecognized as so-called poliomyelitis. Then a child here and there develops spinal symptoms rather suddenly and the gastro-intestinal symptoms are minimized or forgotten.

Strangely enough, paralyses are more common in the northern than in the southern parts of this country. This is comparable to diseases like pernicious anemia and rheumatic fever which are not as frequent and are milder in the South than in the North.

Burrows thinks that in a disease so widespread as this one, where the paralysis is an infrequent complication of the general lymphatic pathological lesion, the chances of suppressing its spread by the present methods of quarantine are not going to be successful. "To protect any person against it would necessitate complete isolation throughout his entire life."

"The disease is probably transmitted from pateint to patient by direct contact." The virus may be carried by those who have had such a mild attack that it has not been recognized. The enormous number of children affected make it impossible to protect them unless some method of universal protective inoculation could be carried out. The reason why children are affected rather than adults is the same as that for measles, viz., the adults have been immunized by the mild or abortive types in childhood.

If this be so, and serum is found to be of value in preventing paralyses, why would it not be a sensible idea to make more use of serum obtained from any healthy adult?

Burrows feels that the name poliomyelitis is a misnomer and should be dropped. He proposes "acute lymphatic hyperplasia" which would include all cases of the disease.

It does not seem to the writer that we should as yet change our quarantine regulations. We should, however, recognize the constant prevalence of the disease in centers of dense population and attempt to keep children in as healthy a state as possible so that their general resistance will remain high. Fortunately, studies show that the majority of children seem to be naturally immune. Those who have had the disease in a mild form and become carriers are the real danger. No one knows for how long the carrier may remain infective. The problem is a huge one. It will undoubtedly be some time before it is solved. Much more will have to be known concerning the filterable viruses.

L. M. W.

"AT LEAST $500"

"THE State Medical Society of Wisconsin has saved me at least $500 in the last two years."

That statement by a member visiting the last annual meeting was so arresting that we demanded the details. He then explained that he was one of those who took the postgraduate medical extension course in pediatrics some two years ago.

"Since that time my ability to handle these cases has materially improved. As a result of this fact alone, I know that the course has saved me at least $500 in the past two years, to say nothing of an increased prestige, that has undoubtedly brought me other cases. And withal, I live just twenty miles from a well known clinic which might be expected to 'cut' rather deeply into my territory with its specialist in pediatrics."

We believe this member's comment is an editorial in itself and so we print it just as it was given to us.

THE PRESIDENT'S COMMITTEE

ELSEWHERE in this issue is reported the approval of our House of Delegates to the proposal of Dr. Fiedler that a special committee be appointed to study the questions embodied in the subject of distribution of medical services. Those who are called upon to serve their associates by membership on this committee have presented to them the largest opportunities for as constructive and far-reaching piece of work as has ever been presented to any committee of our Society.

The President is to be commended for inaugurating this study, so basically essential for the future welfare of the profession and those we serve.

Otho A. Fiedler, M. D., President

State Medical Society of Wisconsin, 1932

Born in Wisconsin in 1873, Dr. Otho A. Fiedler graduated from Wisconsin State Teachers College at Whitewater, secured his medical degree at Marquette University School of Medicine which was followed by two years of postgraduate work at Vienna. For six years Dr. Fiedler was professor of chemistry at Marquette and for two years, professor of medicine. While in Milwaukee he was chief of the laboratory service of the Milwaukee Health Department for four years.

Dr. Fiedler is a veteran of both the Spanish-American and World Wars and retired as Lieutenant-Colonel in the Medical Corps. He is a fellow of the American College of Physicians and is chief-of-staff and vice-president of The Sheboygan Clinic.

For fourteen years Dr. Fiedler served as a member of the State Board of Health and was President of the Board at the time of his retirement. For six years he has been Chairman of the Committee on Public Policy of the State Medical Society, is President of the Northwest Regional Conference, trustee of Marquette University School of Medicine and at present represents Wisconsin on the Auxiliary Legislative Committee of the American Medical Association.

THE PRESIDENT'S PAGE

"AND ESAU SOLD HIS BIRTHRIGHT FOR A MESS OF POTTAGE"

ONE of the most valuable and what should be one of the most valued heritages of the medical profession is the respect and confidence in which the public holds and esteems the profession individually and collectively. This regard and trust have developed as the result of hundreds of years of unselfish, sympathetic devotion to patients at times of their greatest mental and physical strain. It would be very difficult to dislodge the family doctor from the high position which he holds in the public esteem, and really no one outside of our profession can accomplish it. If it is to be done it must be from within, as the result of our own conduct. It must result from our treatment of one another and the public. Criticism now being directed against the profession makes us think that we are losing our enviable position.

For what are we exchanging this heritage? Some of us are sacrificing the good name of the group on the altar of commercialism; are making of the profession a business, and engaging in a rivalry that leads to petty jealousies and quarrels that are not understandable to the public, in which they are not interested but which cost the profession its high reputation for unselfish and disinterested devotion to its clientele.

Another condition that puzzles the laity is the fact that members of the profession lend their names, individually and in groups, to advertising schemes and for advertising purposes that have no professional or educational value and are not in the public interest. It must be a matter of surprise and a little disappointment to the public to see 26,000 physicians testify that some cigaret does not irritate the throat. So far as I can determine, the doctors were enticed into doing this by a petty gift.

What does the public think when it reads repeatedly that physicians have been reprimanded or chastised by government officials for violating the letter or spirit of law, or have been convicted in the courts of a form of racketeering by selling their signed prescriptions to some druggist?

What does the public think when it observes our egotism leading us to make extravagant claims for our seeming successes, or our intolerance causing us to disparage earnest effort on the part of our colleagues, or when our individualism keeps us from cooperation with other doctors and causes a division in our ranks? We need cooperation, cohesiveness, and discipline in the group to maintain the highest standard of personal and professional fitness, efficiency, and morality.

Every physician owes it to his profession to become affiliated with its organized units and to participate actively with his confreres in every honest effort to educate the public, to elevate his profession and to improve himself to the end of a greater public good. We have done very well in Wisconsin. Let us continue to deserve our birthright.

The State Medical Society of Wisconsin

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Wood	F. X. Pomainville, Wisconsin Rapids	W. G. Sexton, Marshfield.

SOCIETY PROCEEDINGS

GRANT

A special meeting of the Grant County Medical Society was held on August 29th at the Grantland Club Rooms, Lancaster, to discuss new methods of diagnosis and treatment of poliomyelitis. Speakers at this meeting were Dr. C. A. Harper, State Health Officer, Madison, and Dr. J. E. Gonce, associate professor of pediatrics, University of Wisconsin.

LA CROSSE

The La Crosse County Medical Society held its regular meeting on Sept. 15th, at the La Crosse Club. The meeting was called to order by the President at 8 P. M.

The minutes of the last meeting were read and approved.

The application of Dr. S. M. Welsh for membership to the society was read and turned over to the Board of Censors.

Correspondence and bulletins issued by the Secretary of the State Board of Health concerning infantile paralysis were read. Considerable discussion was aroused.

County Judge Alstrom spoke before the society regarding county cases and the Wisconsin General Hospital.

A motion was made by Dr. G. Gundersen and seconded by Dr. R. H. Gray to have a committee of five appointed to work with Judge Alstrom to look into the proposition of keeping as many county cases in local hospitals instead of sending them to the Wisconsin General Hospital. Motion carried. Committee appointed: Judge Alstrom, Chairman; Dr. R. E. Flynn, Dr. N. P. Anderson, Dr. R. H. Gray, Dr. Sig. Gundersen.

The problem of caring for indigent cases was discussed. The so called "Iowa Plan" was explained and discussed at length. Dr. Flynn made a motion, seconded by Dr. Henke, to appoint a committee including the secretary to bring up the matter of caring for indigent patients by contract between the county medical society and the county commissioners, similar to the "Iowa Plan". Motion carried. Committee appointed, Dr. R. L. Eagan, Chairman; Dr. W. E. Bannen, Dr. D. S. MacArthur.

Dr. Bannen submitted a report of committee appointed by the Mayor and known as the Mayor's Relief Committee.

A motion was made by Dr. Gray and seconded by Dr. G. Gundersen that the physicians of La Crosse County agree to furnish their services gratis to patients certified by the Mayor's Relief Committee, provided, that medicine be furnished by the druggists at cost and the hospitals provide hospital service at the regular county rate; furthermore, that such physicians shall not be expected to contribute in money to the relief drive. Motion carried.

Meeting adjourned. R. L. E.

MARATHON

Members of the Marathon County Medical Society were guests of Dr. and Mrs. A. W. Boslough, Wausau, at a six o'clock dinner on August 18th at their cottage in honor of the 25th annivarsary of Dr. Boslough's entry into the practice of medicine. Dinner was followed by a meeting of the Society.

At the meeting, Dr. W. M. Nesbit, associate professor of ophthalmology, University of Wisconsin, spoke on "Headaches of Nasal Origin," and Dr. E. F. Schneiders of St. Mary's Hospital, Madison, gave an illustrated lecture on "Precancerous and Cancerous Lesions of the Uterine Cervix."

MARINETTE–FLORENCE

The Marinette–Florence County Medical Society held its monthly meeting, Friday evening, August 21st. There was an unusually large attendance and much interest was manifested in the programs.

Dr. John K. Parish of Hermansville, Michigan, presented a paper on "Cisternal Puncture in Meningitis" and Dr. J. W. Boren of Marinette read a paper on "Anterior Poliomyelitis."

On Thursday evening, September 3rd, members of the Society met at St. Joseph's Hospital to see two wonderful films from the Petrolagar Laboratories of Chicago,—"The Anatomy of the Female Pelvis and Perineum" and "Salpingectomy and High Fundic Amputation." They are both very high grade and instructive.

Friday evening, September 4th, a dinner was given in honor of Prof. Otto S. Schwarz of St. Louis, who gave the last of his lectures at the Marinette and Menominee Hospital in behalf of the University of Wisconsin Extension medical lectures, which have been very popular and interesting. The physicians have been very keen for this course and hope they can participate in more in the near future. M. D. B.

OUTAGAMIE

A lecture on "Anterior Poliomyelitis" was given by Dr. M. G. Peterman, professor of pediatrics, Marquette University Medical School, at the monthly meeting of the Outagamie County Medical Society at Conway Hotel, Appleton, on September 1st. A dinner and business meeting preceded the address.

POLK

The Polk County Medical Society held its regular monthly meeting at Dixie Resort, Balsam Lake, on

Thursday evening, August 27th, as the guest of Dr. J. D. Nicholson of Milltown.

Dr. R. G. Arveson of Frederic gave the medical topic "Anterior Poliomyelitis." Interest was added to the discussion by the case history occurring in the family of Dr. Arveson. A round table case history discussion followed the paper. Many diagnostic aids were gained from the discussion. The members of the Society were instructed to send the names of all convalescent cases to the secretary, the list to be made available to any of the members should they find themselves in need of convalescent blood.

Arrangements were made for the joint meeting of the Barron–St. Croix and Chisago–Pine County Medical Societies for the discussion of periodic health examinations. Members were advised that Dr. R. G. Leland, director of the Bureau of Medical Economics of the A. M. A., and Dr. C. B. Wright, Minneapolis, had been secured for the meeting.

The meeting closed with a discussion of the Poor Relief Problem and the present status of our Society contract for caring for the indigent sick.

G. B. L.

TREMPEALEAU–JACKSON–BUFFALO

A meeting of the Trempealeau–Jackson–Buffalo County Medical Society was held on August 28th at Independence.

The program consisted of a paper entitled "Diseases of the Gall Bladder" presented by Dr. A. B. Rivers of the Mayo Clinic. Following this Dr. S. W. Harrington, also of the Mayo Clinic, gave a paper on "Diaphragmatic Hernia." Both papers were illustrated and were very well received by the Society.

Following the scientific program, the members enjoyed a dinner at the hotel. R. L. MacC.

WAUPACA

On September 1st, the Waupaca County Medical Society held its monthly meeting following a six-thirty o'clock dinner at Pines Inn, Waupaca Chain O'Lakes.

Dr. E. W. Exley of Green Bay talked on "General Urologic Diagnosis" illustrated with lantern slides.

Dr. C. E. Roach, Madison, read a paper on "Anterior Poliomyelitis."

A very lively discussion followed, led by Dr. A. M. Christofferson, Waupaca. Dr. Roach was bombarded for one-half hour with questions from everyone present. F. J. P.

ELEVENTH COUNCILOR DISTRICT

Dr. T. J. O'Leary of Superior was elected president of the Eleventh Councilor District of the State Medical Society of Wisconsin at the annual meeting held in Superior on August 20th. Dr. J. W. Prentice of Ashland was chosen as secretary. Ashland was awarded the 1932 meeting of the eleventh district.

The following program was presented:

"Medical Phases of the Goiter Problem" by Dr. W. A. Plummer of the Mayo Clinic, Rochester.

"Surgical Phases of the Goiter Problem" by Dr. Arnold Jackson, Jackson Clinic, Madison.

"Cancer of Colon" by Dr. C. F. Dixon of the Mayo Clinic.

"Prostate Diseases" by Dr. G. H. Ewell of the Jackson Clinic.

In the evening Dr. C. A. Harper, State Health Officer, spoke on "Organized Medicine." Mr. J. G. Crownhart, secretary of the State Medical Society, spoke on "Legislation Affecting the Medical Profession."

MILWAUKEE HOSPITAL INTERNS' ASSOCIATION

The first meeting of the Milwaukee Hospital Interns' Association was held at the home of Dr. John McCabe on September 16th, at eight p. m. Business of the evening was the election of officers, after which a luncheon was served. The last meeting of the Association was in the form of a picnic, held in June. A very ambitious program has been planned for the ensuing year.

NEWS ITEMS AND PERSONALS

Dr. and Mrs. W. J. Wehle of West Bend returned on August 8th from a vacation trip to the coast, visiting their sons in Los Angeles. They also visited Rocky Mountain National Park in Colorado and Banff National Park in Canada.

—△—

Dr. H. E. Kasten, Beloit, plans to re-open his offices shortly after the first of December. His future practice will be limited exclusively to urology and dermatology. At present Dr. Kasten is spending eight months in Europe in post-graduate study in the clinics of Professors Oppenheim, Arzt and Blum in Vienna, von Lectenberg in Berlin and Marriott in Paris. Dr. Kasten is presently in Berlin and will complete his work in Paris in November, stopping for a few days in London before returning.

—△—

Doctors William and Wesley Van Zanten announce the opening of their new medical building at 813 St. Clair Avenue, Sheboygan. The building, a two-story, brick structure with offices for physicians and a dentist, a laboratory and x-ray department on the first floor, apartment dwellings upstairs, is located just off the main business street between two traffic

arteries where parking space is ample. It is a modern medical building with up-to-date equipment and adapted to serve the public in every possible way.

—△—

Dr. M. Meredith Baumgartner, formerly associated with Dr. Fred Sutherland of Janesville, is now affiliated with the Pember-Nuzum Clinic at 500 West Milwaukee Street, Janesville.

—△—

Dr. Charles A. Dawson, River Falls, was unanimously elected department commander of the Wisconsin American Legion at its state convention in Chippewa Falls on August 19th.

—△—

Dr. A. J. Shimek, Manitowoc, was elected city physician of Manitowoc to take the place of Dr. F. F. Zboralski, who resigned because of plans to locate elsewhere.

—△—

Dr. R. L. Troup of Green Bay attended the annual meeting of the American Roentgen-Ray Society, September 22 to 25, at Atlantic City.

—△—

Dr. W. T. Lindsay, Madison, was re-elected president of the Madison Public Welfare Association at a directors' meeting on September 11th.

—△—

Dr. W. W. Kelly, president of the Board of Education of the city of Green Bay, spoke before a meeting of Green Bay school teachers on health protection for children in the schools.

—△—

The new Racine Clinic, which was formally opened on August 31st, is sponsored by two Racine physicians, Dr. C. F. Christensen and Dr. C. E. Constantine.

—△—

Dr. C. J. Moran, La Crosse, is taking a six weeks' postgraduate course in medicine and surgery at the United States Army school, Harrisburg, Pa.

—△—

The wonderful work being done by the Kiwanis Club of Janesville through its clinic and health service was explained at a meeting of the Club in the Myers Hotel recently by Dr. T. J. Snodgrass, a member of the Club and of its doctors' committee. Dr. Snodgrass exhibited a number of x-ray photographs of the work done on various patients and also had several of the children now confined in the Kiwanis section present at the meeting.

—△—

Dr. I. G. Babcock of Cumberland addressed a meeting of teachers at Barron, Wisconsin.

—△—

At the annual banquet for the medical staff of St. Mary's Hospital, Green Bay, the following were elected officers for the coming year: Dr. F. L. Crikelair, president, Dr. A. J. McCary, vice-president, Dr. James C. Colignon, secretary-treasurer, and Dr. L. D. Quigley, member of the executive board.

Dr. Karl R. Icks, who completed his internship at Milwaukee Hospital, Milwaukee, returned to Green Bay the latter part of August to open offices in the Gray Building.

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Articles of incorporation for the Appleton Clinic, Inc., were filed in August with the Outagamie County register of deeds. The incorporators are Dr. V. F. Marshall, Dr. Carl D. Neidhold and Mr. E. F. Dettmann. The capital stock is $25,000 consisting of 25 shares valued at $1,000 each.

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Physicians from various parts of the state who attended the dedication ceremony of the Beaumont Memorial at Prairie du Chien on August 30th included: Drs. R. E. Mitchell, Eau Claire; Mina B. Glasier, Bloomington; E. A. A. Dunn, Platteville; E. H. Spiegelberg, Boscobel; E. R. Schmidt, Madison; C. R. Bardeen, Madison; W. S. Middleton, Madison; A. J. McDowell, Soldiers Grove; A. E. Dillman, Steuben; D. S. MacArthur, La Crosse; C. A. Harper, Madison and William Snow Miller, Madison.

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Dr. S. M. Welsh, who completed internship at St. Francis Hospital, La Crosse, is now associated with Drs. Evans, Bannen, McGarty and Evans, State Bank Building, La Crosse. Most of his work is confined to the practice of pediatrics and obstetrics.

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The Pember-Nuzum Clinic, Janesville, announces the association of Dr. Francis M. Frechette. His practice is limited to internal medicine and obstetrics.

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Dr. B. C. Brett, Green Bay's oldest resident and Civil War veteran, quietly celebrated his 98th birthday at his home with his children and grandchildren on Sunday, August 23rd. Dr. Brett served as army surgeon for three years during the Civil War as a member of the 21st regiment. After the war, Dr. Brett practiced medicine in Green Bay for 48 years, retiring in 1913. Since that time he has devoted himself to his family and to various hobbies.

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A team of 12 Appleton lawyers defeated a team of 12 Appleton physicians in a competitive golf match. Dr. W. J. Frawley was low for the physicians.

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Speakers on the program for Racine's "Health Day" on October 2nd included: Dr. C. A. Harper, state health officer; Dr. John P. Koehler, Milwaukee health department head; and Dr. Hoyt Dearholt, executive secretary of the Wisconsin Anti-Tuberculosis Association.

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Dr. W. W. Bauer, was re-elected health commissioner for Racine for a term of four years, at a meeting of the city council in August.

Dr. C. J. Combs, Oshkosh, addressed a meeting of the New London Rotary Club.

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Mrs. C. A. Wright, wife of Dr. C. A. Wright, of Delavan, died suddenly on August 11th following a heart attack.

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Dr. and Mrs. R. S. Fisher of Allenton visited in Mankato and Rochester, Minnesota, during August.

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Dr. A. L. Farnsworth of Baraboo received chest bruises when a tourist's automobile collided with his coupe at an intersection.

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The number of live births in the state during the first six months of 1931 totaled 25,812, which was a decrease of 1,170 from the corresponding period of 1930, according to the Bureau of Vital Statistics of the State Board of Health.

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Dr. John O. Muehlhauser, a former member of Brown–Kewaunee County Medical Society and who recently returned from Wurzburg, Germany, has opened offices in the Lawrence building at Sturgeon Bay.

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After going to the trouble of carting away a 250 pound safe from the office of Dr. B. J. Fosse, Beloit, and breaking it open with sledges only to find it contained no cash, the burglars hid it in a cornfield. It was found a few days later by the owner of the farm. The robbers did not molest papers and medicine, the only contents of the safe.

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Dr. R. G. Mills of Fond du Lac was elected chairman of the Y. M. C. A. Physical Committee.

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Dr. and Mrs. J. A. Junck and family returned to their home in Sheboygan early in September, after spending some time at Blue Lake near Minocqua, where Dr. Junck recuperated from a nervous breakdown.

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Dr. E. L. Sevringhaus, associate professor of medicine, University of Wisconsin, addressed a meeting of the American Businessmen's Club in the Loraine Hotel in September.

—△—

Dr. Sarah I. Morris, associate professor of clinical medicine at the University of Wisconsin, has accepted an acting professorship of preventive medicine at the Women's Medical College of Pennsylvania at Philadelphia. She is on a year's leave of absence from Wisconsin.

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Members in the neighborhood of Winona, Minnesota, attended the second annual opening of the Postgraduate Medical Club on September 23rd at the Arlington Club, Winona, where motion picture studies were presented. The members have also been invited to attend the lectures to be given on October 14th and October 28th.

Dr. and Mrs. Louis Fauerbach, Madison, returned from an outing spent at Star Lake in September.

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Robert Van Valzah, Jr., 18, son of Dr. Robert Van Valzah, professor of clinical medicine, University of Wisconsin, sailed on September 25th for England, where he joined the Field-Oxford expedition to Mesopotamia. The expedition will spend a year in Mesopotamia studying ancient civilizations with a joint archeological expedition from Field museum, Chicago, and Oxford, England. The past summer, Robert spent in Arizona and New Mexico, doing archeological work on early American civilizations for the Logan museum, Beloit college.

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MILWAUKEE

Dr. Griffith Jones and Dr. John Gates have been reappointed school physicians in Wauwatosa.

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Dr. and Mrs. Claude S. Beebe and daughters, Adela and Betty, motored through Switzerland. They returned to Milwaukee the early part of September.

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The most recent addition to the Children's Hospital, an isolation department for children, was opened on August 19th. An entire story has been added to the hospital at a cost of $60,000, which makes Children's Hospital one of the most completely equipped of its kind in this part of the country. The construction was planned under the supervision of a building committee of which Drs. Herman Schumm and Stanley J. Seeger were members.

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Dr. Nelson M. Black, formerly of Milwaukee, now living in Miami, Florida, was a recent guest at the home of Dr. and Mrs. Otto H. Foerster.

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Definite plans for the medical care of Milwaukee County indigents are expected to be made when the Special Committee on Care of the Indigent, recently appointed by Dr. E. L. Tharinger, President of the Society, meets with Mr. W. L. Coffey, Manager of the County Institutions, the County Board of Trustees, and representatives of the County Institutions, the early part of September.

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Health talks, sponsored by the Wisconsin State Board of Health, and given by Mr. Theodore Wiprud, executive secretary of the Medical Society of Milwaukee County, were resumed and broadcast over the Milwaukee Journal Station, WTMJ, weekly, beginning October 2. All of the broadcasts will be made on Fridays, and the following subjects will be given over the air during the month of October:

Good nature and good health.
Anemia.
Dust.
Epilepsy.
High Blood Pressure.

Dr. Leslie LeCron, who has been visiting at the home of Dr. and Mrs. Wilbur LeCron has returned to Baltimore.

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Dr. S. M. Turkeltaub, Milwaukee, returned on September 13th from Rochester, Minnesota, where he spent three weeks visiting the Mayo Clinic.

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Dr. E. L. Miloslavich, director of the department of clinical pathology and medical research at St. Mary's Hospital, addressed the Marquette University Physics Club on the problem of "Electro-Pathology", on March 17th. He also spoke on the subject of the work of the "Field Criminologist" at the meeting of the Northwest Y. M. C. A. on March 18, and on "Scientific Approach of a Crime Affair", on March 23, before the Calvary Evangelical Men's Club.

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Dr. Everett Tomb, for the past two years a junior member of the Medical Society of Milwaukee County has moved to Framingham, Massachusetts, where he is now practicing.

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Dr. Karl E. Kassowitz, professor of pediatrics at Marquette University, with his family has returned to Milwaukee after a visit to Glacier National Park, where they enjoyed a vacation of mountain climbing and hiking.

—△—

Dr. A. J. Patek has returned to Milwaukee after a pleasant vacation in the form of a hiking and camping trip through Jasper National Park. He was accompanied by a group of friends.

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Dr. and Mrs. Hoyt E. Dearholt have announced the engagement of their daughter, Miss Dorothy Dearholt, to Mr. Timothy W. Goodrich, of Hartford, Connecticut.

—△—

Dr. and Mrs. Carl Eberbach have returned from an extended cruise of the Great Lakes.

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Dr. and Mrs. U. Senn recently returned from a week's vacation spent at Lake Koshkonong, Wisconsin.

—△—

Dr. and Mrs. Roland S. Cron, together with a group of friends, recently spent a few days in northern Wisconsin.

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Dr. John W. Powers addressed the first meeting of the medical staff of the Milwaukee General Hospital of the Maternity Hospital and Dispensary Association on Tuesday evening, September 1st. Dr. Malcolm M. Hipke also spoke.

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The Medical Society of Milwaukee County will have as its principal speaker at the Society meeting on November 13th, Dr. Charles Spencer Williamson, professor of medicine of the University of Illinois College of Medicine in Chicago.

Perfect golf weather prevailed on August 26th, when 75 Milwaukee physicians met in the annual golf tournament sponsored by the Milwaukee County Physicians' Golf Association, at the Brynwood Country Club, Milwaukee.

Following the tournament, dinner was served at the club house, at which time prizes were distributed, as follows:

Low gross score, Dr. F. J. Schubert; 2nd low gross score, Dr. J. E. Rueth; 3rd low gross score, Dr. F. B. McMahon; Low net score, Dr. J. F. Zivnuska; 2nd low net score, Dr. J. A. Jenner; 3rd low net score, Dr. W. A. Brussock; Low gross foursome, Drs. S. R. Mitchell, E. C. Bach, Mark Bach, A. J. Weber; Low net foursome, Drs. F. J. Schubert, J. F. Zivnuska, C. C. Reinke, E. A. Brzezinski; Fattest man, Dr. E. L. Bernhart; Leanest man, Dr. C. M. Echols; Youngest man, Dr. Benjamin Urdan; Noisiest man, Dr. A. I. Rosenberger; Best-dressed man, Dr. Frank Thompson; Handsomest man, Dr. H. B. Podlasky; Best all-around man, Dr. M. F. MacRae; Most valuable man, Dr. C. W. Morter.

After the dinner a business meeting was held at which Dr. Frank Thompson was elected President, and Dr. H. B. Podlasky, Secretary and Treasurer.

The tournament aroused a great deal of interest among the Society members, and the physicians are looking forward to the 1932 meet.

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Dr. and Mrs. Millard Tufts have returned from a fishing trip at Conover, Wisconsin.

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Definite plans have been worked out for the establishment of a bureau of blood donors, and operation of the bureau will get under way as soon as the number of hospitals that will lend assistance is determined. It is felt this bureau will provide a long-needed service for Milwaukee hospitals. Plans for such service were worked out by Dr. E. L. Tharinger, president of The Medical Society of Milwaukee County, together with Dr. Norbert Enzer, of Mt. Sinai Hospital, and Mr. Theodore Wiprud, executive secretary of the Society.

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Because of the numerous demands for another public speaking course, Professor H. L. Ewbank of the department of speech, University of Wisconsin, has been prevailed upon to return. An advanced as well as an elementary course will be given.

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The August campaign for diphtheria immunizations, conducted jointly by The Medical Society of Milwaukee County and the Milwaukee Health Department, proved very satisfactory. More children were immunized in the first two weeks of August than during the entire month of August, 1930.

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At a meeting of the educational committee, held August 18th, the proposed demonstration of the periodic health examination form was discussed and planned. It was agreed that the meeting should begin in the morning and last throughout the day

and into the evening. No definite date has been set, but the demonstration will take place the latter part of September.

Postgraduate courses were planned for the winter months; first a course on the nervous system; second, the heart, and third, a course in gastroenterology. The Executive Secretary of the Society was asked to make plans for these courses and submit them to the committee.

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Dr. Stephen Cahana, a delegate of the State Board of Health, attended the National Health Conference at Montreal, Quebec, Canada.

—△—

Dr. David Wigod, who has practiced medicine for several years in Milwaukee, has left for Weimer, California, where he expects to make his home.

—△—

Dr. John Freedman has given up his practice in Milwaukee and is now connected with the University of Illinois College of Medicine, in Chicago.

—△—

Dr. C. W. Morter and family recently enjoyed a vacation at Star Lake, Wisconsin.

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Announcement has been made that on a basis of performance and experience Dr. Harry B. Sadoff has been appointed as one of two Americans to the position of resident surgeon in the Hospital for Joint Diseases in New York City.

For the next two years, beginning January 1, 1932, Dr. Sadoff will be connected with the orthopedic, bone and joint surgery department of the hospital.

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Dr. and Mrs. William Thorndike recently entertained Dr. Paul Thorndike of Boston, Massachusetts.

—△—

At commencement exercises for the graduates of the Milwaukee General Hospital School of Nursing, held on September 17, Dr. M. W. Sherwood spoke on behalf of the hospital staff.

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Dr. J. P. Koehler, Dr. R. E. Hickey, Dr. George Barth, and Mr. George Dundon, of the Milwaukee Department of Health attended the national convention of the American Public Health Association in Montreal. They invited the convention to come to Milwaukee in 1933.

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Dr. A. T. Holbrook addressed the graduating class of the Columbia Hospital School of Nurses at their exercises held at the Milwaukee University School on September 16th.

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Tribute was paid the late Dr. Joseph Schneider on Sept. 13th, when thousands of persons gathered in Doctor's Park, Dr. Schneider's gift to the public, where memorial services were held.

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Mr. H. J. Wicks, of Minneapolis, was a recent visitor to the executive offices of The Medical Society of Milwaukee County. He came in the interests of the Hennepin County Medical Society of Minneapolis, which is contemplating the employment of an executive secretary.

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Dr. and Mrs. Gilbert Seaman have returned to Milwaukee after spending the summer months at their summer home in Oconomowoc.

—△—

Dr. and Mrs. H. W. Shutter have returned from an extended European trip.

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Definite plans for the establishment of a Bureau for Blood Donors have been made, and from the expressed enthusiasm of Milwaukee hospitals, it is felt that the establishment of such a bureau will be a boon to both the medical profession and the public of Milwaukee County.

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Organizations of Milwaukee are most appreciative of the Speakers' Bureau, established by the Medical Society of Milwaukee County. On September 17th Dr. L. M. Warfield spoke before the Gyro Club on "What You Should Know About Your Heart." On that same day Dr. H. W. Powers addressed the Fratney School Parent-Teacher Association on "Character Formation in the Child." Calls are being received almost daily requesting the services of a speaker listed with our Speakers' Bureau.

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On September 30th, at the Academy of Medicine, the use of the periodic health examination form, developed by the Educational Committee, was demonstrated. There were two demonstrations—one from 3 to 5 P. M. and the other from 8 to 10 P. M. Dr. Edmund F. Foley, assistant professor of medicine, College of Medicine, University of Illinois, conducted both demonstrations, following a discussion on "Physical Diagnosis."

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The Medical Society of Milwaukee County feels itself very fortunate in having secured Dr. Irving S. Cutter, Dean of Northwestern University Medical School, for its annual dinner meeting to be held on December 10th.

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At the monthly meeting of the Society, to be held at the Hotel Pfister on November 13th, Dr. Charles Spencer Williamson, professor of medicine, University of Illinois College of Medicine, Chicago, will be the principal speaker.

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A meeting of The Medical Society of Milwaukee County, will be held at the Hotel Pfister on October 14th. A special medical economics program, sponsored by the Educational Committee, has been planned, at which Mr. Hugh W. Grove, vice-president and trust officer of the First Wisconsin Trust Company, and Mr. Robert Aurner, professor of business administration, University of Wisconsin, will address the members on some phases of economics.

A meeting of the special committee on the care of the indigent of Milwaukee County was held at the Wisconsin Club on September 11th. At this meeting were members of the committee, members of the board of directors, Mr. W. L. Coffey, and Drs. H. W. Sargent, O. R. Lillie, Eugene A. Smith, Frank Thompson, Joseph Lettenberger, and T. J. Howard, of the medical staff of the County Institutions.

The proposed plan of the Society, which would do away with the present district-physician plan, was discussed at some length. No conclusion was reached, however, but the Society expects to submit a definite plan as soon as all available information is at hand.

BIRTHS

A son to Dr. and Mrs. Francis D. Murphy, Milwaukee, on August 18th.

A daughter to Dr. and Mrs. R. H. Fredericks, Milwaukee, on September 14th.

A son, George William, to Mr. and Mrs. J. G. Crownhart, Madison, September 27th.

ENGAGEMENTS

Dr. Edward S. Schwade, Milwaukee, to Miss Stella F. Pereles, also of Milwaukee.

Dr. Maurice B. Byrnes, Milwaukee, to Miss Mary Wilkinson, daughter of Dr. and Mrs. M. R. Wilkinson of Oconomowoc.

MARRIAGES

Dr. Michael W. Shutkin, Milwaukee, to Miss Louise Babette Wetzler, daughter of Dr. and Mrs. Sidney H. Wetzler of Milwaukee on September 7th. They will spend from six to nine months in Europe studying and upon their return, Dr. Shutkin will specialize in medical and surgical gastro-intestinal diseases and gall bladder.

Dr. Stephen S. Stack, Jr., Milwaukee, to Mlle. Marie Therese Dardaillion of Paris. The wedding took place in Paris.

Dr. O. P. Schoofs, Milwaukee, to Miss Alma Haug, also of Milwaukee on July 14th.

DEATHS

Dr. Lorenzo Boorse, Milwaukee, died on September 12th after an illness of eight months.

Dr. Boorse was born in the year 1859 in Granville, Wisconsin. He entered Rush Medical College and received his degree in 1881. For thirty years, Dr. Boorse was professor of pediatrics in the Wisconsin College of Physicians and Surgeons. He instructed the first class of graduate nurses in Wisconsin. For many years he was on the staffs of the Milwaukee County Hospital, and St. Joseph's Hospital school for nurses. In the World War, Dr. Boorse was in the United States medical service. He was state committeeman for the medical section of the council on national defense.

He was a member of the Medical Society of Milwaukee County, the State Medical Society and the American Medical Association. He was also a member of the Milwaukee Pediatric Society, and the Middle States Pediatric Society.

Dr. Boorse is survived by his widow, one son and one daughter.

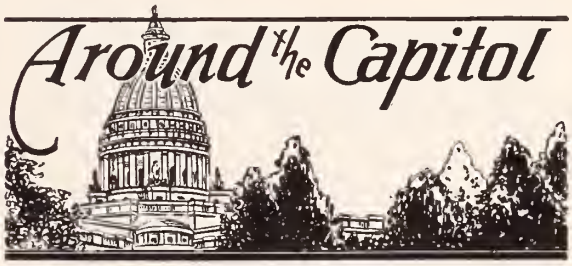
SOCIETY RECORDS

New Members

Charles F. Myre, Chippewa Falls.
Emmett F. Guy, Oostburg.
Otis M. Wilson, 502 Third St., Wausau.
Wesley Wm. Van Zanten, Sheboygan
G. T. Hegner, 521 W. College Ave., Appleton.
Rodney J. Gray, Brooklyn.
Ivan G. Ellis, St. Mary's Hospital, Madison.
Isadore Schultz, Mazomanie.
Robert Wheeler, 110 E. Main St., Madison.
Walter Reineking, Lake View Sanatorium, Madison.

Changes in Address

J. A. Hernandez, Athens to 202 Grand Ave., Wausau.



A new $737,000 Forest Products Laboratory to be constructed in Madison will be the largest in the world for wood research. The present University of Wisconsin poultry farm, one-half mile west of the stock pavilion has been selected as the site for the structure. The contract has been awarded by authorities of the U. S. Department of Agriculture, Washington, and the laboratory is to be completed within a year.

* * *

The state board of health announced that cancer continued its march as an increasing menace to Wisconsin lives by taking a toll of 1,710 during the first six months of 1931. In the corresponding period of 1930 the cancer toll stood at 1,660, according to the state bureau of vital statistics. Early diagnosis and prompt treatment are urged by the state board of health as the most effective means of combating the disease.

* * *

In experiments to learn more about effects of x-rays upon evolution, an annual plant has been changed into a perennial at Cornell university. The

plant which changed its nature is the euchlaena, the closest wild relative to corn. Some of the seed was exposed to x-rays for a few minutes and then germinated. The young stalk began life as an annual, but later on, while still young, it developed some of the appearances of a perennial. Then the annual portion dried up and disappeared, and the remaining stalk developed into a true perennial.

* * *

A relief for hiccups is described by Dr. L. A. Golden, Boston, in a report reviewed by the American Medical Association. All that is necessary is an ordinary paper bag of medium size and strength. This is placed over the patient's face and is held so tightly that it encloses the mouth and the nose. The patient then is told to breathe into the bag and out of it, the result being that the same air is breathed over and over again. Dr. Golden points out, that such an excess of carbon dioxide in the air that one breathes often helps to cure hiccups.

* * *

One thousand and one loans and scholarships having a total value of $83,337.00 were granted by the faculty committee on loans and undergraduate scholarships of the University of Wisconsin during last year, it has been revealed by a report recently compiled by Prof. Julius E. Olson.

* * *

"Drug Sundries" cannot be used as a store sign by any store which is not a regular pharmacy because it has a meaning similar to "drug store," Fred M. Wylie, deputy attorney general, advised B. J. Kremer, president of the state board of pharmacy, Wednesday.

» » » CORRESPONDENCE « « «

GOITER NOMENCLATURE

American Association for the Study of Goiter

Wisconsin Med. Journal,
Madison, Wis.
Dear Sirs:

RE: Goiter Classification and Nomenclature.

This association would appreciate very much your giving wide publicity to its approval of the following classification and nomenclature:

Clinical Classification:

Type 1—Non-toxic Diffuse Goiter

Type 2—Toxic Diffuse Goiter

Type 3—Non-toxic Nodular Goiter

Type 4—Toxic Nodular Goiter

Nomenclature:

Our association advocates a policy of using the simplest and yet the most descriptive terminology possible.

The use of proper names, while it is impossible to dispense with many well established ones in goiter literature, be discouraged; as should coined words invented to popularize a fad or fancy.

Emphasis should be made upon the importance of not confounding varieties and sequelae with types. The use of such terms as exophthalmic, hemorrhagic, cystic, adolescent, colloid, intra-thoracic, substernal and congenital are perfectly proper when used to describe varieties, but only constant characteristics should be used to designate types.

Thanking you very much for your cordial co-operation, I am

Fraternally yours,
J. R. Yung, M. D.,
Corresponding Sec'y.

STILL AT IT DESPITE 87–1 VOTE

Delavan, Wis.

Member of The Wisconsin Legislature:
Dear Sir:

The Anti-Vivisectionists believe that honest, right-minded people, thinkers, who want justice in all things, welcome opinions on both sides of any question, providing the issue is of national importance and concern. The question of vivisection is not only of national concern but there is a world move against it! The people who are enlightened regarding this question are protesting! Doing evil that good may come can never commend itself as sound principle to any conscientious individual!

The opinions of the greatest physicians and surgeons the world over, men whose established reputations give value to their opinions, is that animals are so differently constructed from the human race that by no possibility could a mutilation of animals result even indirectly in alleviating the ills of mankind.

The Anti-Vivisection creed implies no condemnation of true and useful knowledge, but it does deny that knowledge which shall be of true and lasting benefit to mankind can be obtained by the conscious exploitation of helpless, living creatures! Just as long as the people selfishly allow hideous tortures to be carried on behind closed doors "in the name of science" with the hope that they can find a cure for their own self-imposed sins, just as long will it reflect back upon the people with disease and disaster of every kind. The law of justice operates unseen!

Disease is on the increase, despite the juggled reports of the health bureaus, aided by the billion dollar financial interests of the vaccine and serum factories! The ever-increasing trend of the public away from the orthodox medical man to the so-

called "unethical healers" of other schools proves beyond a shadow of doubt that orthodox medicine does not deliver the goods! If medicine has really advanced and has done half the good that is claimed for it, there would not be such a shocking increase in hospitals all over the country—an increase which is far in advance of the natural increase in population. The hospitals would begin to empty instead of being filled to overflowing, and more and more continually being built.

Prof. Walter J. Meek, of the University of Wisconsin, said in his argument against Anti-Vivisection that the opinions of the Anti-Vivisectionists rest on a "a mass of misunderstanding and misinformation." That statement is untrue and unfair, because hundreds of Anti-Vivisectionists are recognized physicians and surgeons of the highest standing and it is from these great doctors that much of our information comes. The Anti-Vivisectionists also get their information from medical students and from the vivisectors themselves!

The "evidence" in favor of vivisection and "claims" of its benefits come entirely from men and women who are engaged in that business! Vivisectors are not competent witnesses in this controversy. There is too much of an element of self interest!

We—the people—are the accusers of this wicked system of medicine which has come into being during the last half century; we are calling these inhuman and greedy medical men to the Bar of Justice! We—the tax payers—support the larger part of the vivisection that is being carried on. We have the right to demand that it be stopped in the name of humanity and because of its proven futility!

Millions and millions of animals are being tortured annually, under the false pretense that it is for "the good of humanity", by medical sadists in our universities and laboratories of so-called "medical research", just to gratify their developed craze for cruelty and to gain a full pocket-book!

Vivisectors and their upholders continually lull the people to sleep with the comforting assertions that there is no cruelty in the laboratories. Those are deliberate lies, for they are torturing animals beyond all conception of the human mind while they are conscious and strapped down. And these torture chambers now dot our country where this commercialized torture is carried on!

There is money in it!

Vivisection is not only causing untold suffering to countless animals, but it is causing an alarming increase in disease and lowering the moral standards of the people!

Do not take the word of the so-called "Humane Officers" that there is not any cruelty in the laboratories—they are undoubtedly working in the interest of the medical trust! To claim to be humane and uphold the worst form of cruelty is the very height of hypocrisy!

Undoubtedly there is money in it for them too!

Professors and their wives are joining Humane Societies for the sole purpose of keeping the subject of vivisection from being ventilated! They are working in defense of their pocket-books!

The newspapers will do practically nothing toward exposing the crimes of vivisection. They are afraid to oppose the American Medical Association—the most powerful and most tyrannical organization on earth—and who are advertising so extensively in their pages.

We can and will furnish proofs that vivisection is useless and cruel. We will answer any question that you care to ask. Will you not look deeply into this question? Help us to stamp out this infamy of the modern age. It is a disgrace and an insult to humanity!

You have been put in the Legislature by the people to make laws in the interest of the people—and it is for the good of the people as well as the animals that this disgraceful practice be abolished by law! Remember the eyes of the judge of all the earth are upon you!

Yours for kindness, justice and mercy—to every living creature.

Winifred Wilkins,
Delavan, Wis.

"FINEST MEETING"

Racine, Wis., September 15, 1931.

J. G. Crownhart, Sec'y,
State Medical Society,
Madison, Wis.

Dear Sir:

I hope that you have and will receive many expressions of appreciation for our fine society meeting at Madison. The heat was very unfortunate, but it was most evident that the plans were well laid for the finest meeting which we have ever had. I want to add my personal thanks to the many whom I heard say were very grateful.

Yours very truly,
Robert C. Thackeray.

WITH THE STATE PRESS

The committee on medical care, meeting in Washington some time ago, estimated the nation's annual medical bill at the modest total of $3,107,000,000, or about $26 for every man, woman and child in this country. The committee was of the opinion that this was only half enough—that proper medical care for all would require something like $6,000,000,000.

Of the amount now being spent, the committee estimates that about $1,000,000,000 goes to the doctors for their services, $700,000,000 for medicines and supplies, $550,000,000 for hospital bills; dentistry work, $400,000,000; public health, $86,000,000, and the balance to optometrists and opticians, chiropractors, osteopaths, chiropodists, dispensaries and midwives.

Contemplating such staggering figures makes the average person wonder if our country is not a nation of invalids, and the recommendation that we

should spend double the present amount for medical service adds to our dilemma.

And one wonders, in the face of these figures, if the American people shouldn't begin to think of preventive medicine.

They might think and act in three days. First, each individual could, so far as possible under present conditions, do only those things which make for good health. Second, the public could socialize the healing industry. Third, the public could socialize the other great industries, so as to bring about conditions in which it would be possible for all of the people to live healthful lives.

—The Milwaukee Leader.

Editorial Board Names Dr. John Huston as Medical Editor

Dr. John Huston, Milwaukee, was selected by the Editorial Board at a special meeting in September to be medical editor of the Wisconsin Medical Journal. Born in Richland Center, Wisconsin, Dr. Hutson was graduated from the University of Wisconsin in 1919 and for the next year was instructor in pathology while securing his master's degree. Dr. Huston graduated from Harvard Medical School in 1923 and was house officer of Boston City Hospital from 1923 to 1925.

He was instructor in medicine at the University of Michigan from 1925 to 1929. Dr. Huston moved to Milwaukee in the latter year and has since been engaged in the practice of internal medicine. He is presently an instructor in medicine at Marquette University school of medicine and supervisor of extra mural instruction of University of Wisconsin students in Milwaukee. He is a member of the staff of the department of preventive medicine for the A. O. Smith Corporation and a member of the staff of St. Luke's Hospital.

Dr. Huston, acting under the direction of the Editorial Board, will assist in the work incidental to the editing and publishing of scientific papers in the Journal and in developing the scientific sections of the Journal. Announcement of his appointment in that capacity was made by Dr. Oscar Lotz, chairman of the Editorial Board at the September meeting of the House of Delegates.

John Huston, M. D.

Interstate Postgraduate Meets in Milwaukee October 19-23; Final Program for Medical Assembly Announced

With a clinical and didactic program that occupies five days of sessions, several thousand physicians will meet in Milwaukee this month for the Medical Assembly of the Interstate Postgraduate Medical Association of which Dr. Edwin Henes, Jr., Milwaukee, is Executive Secretary.

The Association sessions at the Auditorium, purely postgraduate in nature, are open to all members of the State Medical Society upon payment of the $5 registration fee. The final program as announced by Managing-Director William B. Peck, follows:

Monday, October 19th

7:30 A. M.

Diagnostic Clinic (Medical).
Dr. Elsworth S. Smith, Emeritus Professor of Clinical Medicine, Washington University School of Medicine, St. Louis, Mo.

Diagnostic Clinic (Obstetrical).
Dr. Irvin Abell, Clinical Professor of Surgery, University of Louisville School of Medicine, Louisville, Ky.

Diagnostic Clinic (Medical).
Dr. Harlow Brooks, Professor of Clinical Medicine, University and Bellevue Hospital Medical College, New York, N. Y.

Diagnostic Clinic (Surgical).
Dr. Frank H. Lahey, Director, Lahey Clinic, Boston, Mass.

Intermission for Review of Exhibits

Diagnostic Clinic (Pediatric).
Dr. Alan G. Brown, Professor of Pediatrics, University of Toronto Faculty of Medicine, Toronto, Canada.

Diagnostic Clinic (Medical).
Dr. Henry A. Christian, Hersey Professor of the Theory and Practice of Physic, Harvard University Medical School, Boston, Mass.

Address: "Chronic Arthritis as an Economic Human Problem."
Dr. Robert B. Osgood, John B. & Buckminster Brown, Emeritus Professor of Orthopedic Surgery, Harvard University Medical School, Boston, Mass.

Noon Intermission

1:00 P. M.

The Thyroid Gland

Address: "The Use of Iodin in Graves' Disease."
Dr. Clarence G. Toland, Associate Professor of Clinical Surgery, College of Medical Evangelists, Loma Linda, Los Angeles, Calif.

Address: "The Use of Iodin in Recurrent Exophthalmic Goiter."
Dr. S. F. Haines, Instructor in Medicine, University of Minnesota, Graduate School of Medicine, Mayo Clinic, Rochester, Minn.

Address: "The Safeguards in the Technic of Operations on the Thyroid Gland."
Dr. Robert S. Dinsmore, Cleveland Clinic, Cleveland, Ohio.

Address: "Thyroiditis."
Dr. Frank H. Lahey, Director, Lahey Clinic, Boston, Mass.

Address: "Cardiac Irregularities Associated with Diseases of the Thyroid Gland."
Dr. Elsworth S. Smith, Emeritus Professor of Clinical Medicine, Washington University School of Medicine, St. Louis, Mo.

Intermission for Review of Exhibits

Obstetrics and Gynecology

Address: "Retroversion of the Uterus, and Complete Prolapse of the Uterus."
Dr. Irvin Abell, Clinical Professor of Surgery, University of Louisville School of Medicine, Louisville, Ky.

Address: "Conservative Treatment of Eclampsia."
Dr. Otto H. Schwartz, Professor of Obstetrics and Gynecology, Washington University School of Medicine, St. Louis, Mo.

Motion Picture: "Suspension of the Uterus for Retro-Displacement."
Dr. Harold O. Jones, Associate Professor of Obstetrics and Gynecology, Northwestern University Medical School, Chicago, Illinois.

The Circulatory System

Address: "Mechanism and Transmission of Heart Murmurs with a Special Consideration of 'The Unimportant Murmur'."
Dr. S. Marx White, Professor of Medicine, University of Minnesota Medical School, and University of Minnesota, Graduate School of Medicine, Minneapolis, Minn.

Address: "Syphilitic Aortitis."
Dr. Wm. S. Middleton, Associate Professor of Medicine, University of Wisconsin Medical School, Madison, Wisconsin.

Address:
Dr. Barney Brooks, Prof. of Surgery, Vanderbilt University School of Medicine, Nashville, Tenn.

Dinner Intermission

7:00 P. M.

Address: "Syndrome of Ayerza."
Dr. Wm. Sharp McCann, Professor of Medicine, University of Rochester, School of Medicine, Rochester, N. Y.

Address: "Circulatory Failure in Acute Infectious Diseases."
Dr. Charles A. Elliott, Professor of Medicine, Northwestern University Medical School, Chicago, Ill.

Address: "Heart Diseases in Children and their Sequelae."
Dr. Alan G. Brown, Professor of Pediatrics, University of Toronto Faculty of Medicine, Toronto, Canada.

Address: "Prognosis of Hypertension."
Dr. Louis Hamman, Associate Professor of Clinical Medicine, Johns Hopkins University School of Medicine, Baltimore, Md.

Address: "Coronary Thrombosis."
Dr. Harlow Brooks, Professor of Clinical Medicine, University and Bellevue Hospital Medical College, New York, N. Y.

Address: "The Diagnosis and Treatment of Adhesive Pericarditis."
Dr. C. Sidney Burwell, Professor of Medicine, Vanderbilt University School of Medicine, Nashville, Tenn.

Address: "Aortic Lesions in Relation to Cardiac Physical Signs and Cardiac Function."
Dr. Henry A. Christian, Hersey Professor of the Theory and Practice of Physic, Harvard University Medical School, Boston, Mass.

Tuesday, October 20th

7:30 A. M.

Diagnostic Clinic (Surgical).
Dr. John F. Erdmann, Professor of Surgery, Columbia University, and Director of Surgery, Post Graduate Hospital of Columbia University, New York, N. Y.

Henry A. Christian, M. D., *President*
Interstate Postgraduate Medical Association

Diagnostic Clinic: "Toxemias of Pregnancy" and "Antenatal Hemorrhage."
Dr. P. Brooke Bland, Professor of Obstetrics, Jefferson Medical College of Philadelphia, Philadelphia, Pa.

Diagnostic Clinic (Surgical).
Dr. John M. T. Finney, Professor of Clinical Surgery, Johns Hopkins University School of Medicine, Baltimore, Md.

Diagnostic Clinic (Medical).
Dr. Campbell P. Howard, Professor of Medicine, McGill University Faculty of Medicine, and Physician to the Montreal General Hospital, Montreal, Canada.

Intermission for Review of Exhibits

Diagnostic Clinic (Surgical).
Dr. F. N. G. Starr, Professor of Clinical Surgery, University of Toronto Faculty of Medicine, Toronto, Canada.

Diagnostic Clinic (Oto-Laryngological).
Dr. Samuel J. Crowe, Clinical Professor of Laryngology and Otology, Johns Hopkins University School of Medicine, Baltimore, Md.

Address: "Allergic Diseases."
Dr. Warren T. Vaughan, Professional Bldg., Richmond, Va.

Noon Intermission

1:00 P. M.

The Gastro-Intestinal Tract

Address: "Peptic Ulcer—A Review of Present Knowledge of Etiology, and Best Methods of Treatment."
Dr. John M. T. Finney, Professor of Clinical Surgery, Johns Hopkins University School of Medicine, Baltimore, Md.

Address: "Surgical Aspects of Carcinoma of the Rectum."
Dr. John F. Erdmann, Professor of Surgery, Columbia University, and Director of Surgery, Post Graduate Hospital of Columbia University, New York, N. Y.

Address: "Cancer of the Stomach."
Dr. F. N. G. Starr, Professor of Clinical Surgery, University of Toronto Faculty of Medicine, Toronto, Canada.

Address: "The Present Status of the Treatment of Hirschsprung's Disease."
Dr. Fred W. Rankin, Associate Professor of Surgery, University of Minnesota, Graduate School of Medicine, Mayo Clinic, Rochester, Minn.

Address: "Does Peptic Ulcer Cause Permanent Disability?"
Dr. Wm. Gerry Morgan, Professor of Gastro-Enterology, Georgetown University School of Medicine, Washington, D. C.

Intermission for Review of Exhibits

Oto-Laryngology

Address: "Plastic Surgery of the Nose, Lips and Cheeks."
Dr. Gordon B. New, Professor of Laryngology, University of Minnesota, Graduate School of Medicine, Mayo Clinic, Rochester, Minn.

Address: "Laryngitis."
Dr. Fielding O. Lewis, Professor of Laryngology, Jefferson Medical College of Philadelphia, Philadelphia, Pa.

Address: "Diseases of the Ear that give Rise to Deafness."
Dr. Samuel J. Crowe, Clinical Professor of Laryngology and Otology, Johns Hopkins University School of Medicine, Baltimore, Md.

Address: "Diagnosis and Treatment of Carcinoma of the Larynx."
Dr. William V. Mullin, Head of the Department of Oto-Laryngology, Cleveland Clinic, Cleveland, O.

Address: "Congenital Syphilis."
Dr. Isaac A. Abt, Professor of Pediatrics, Northwestern University Medical School, Chicago, Ill.

Dinner Intermission

7:00 P. M.

Malignant Diseases

Address: "Malignant Diseases in Childhood."
Dr. H. F. Helmholz, Professor of Pediatrics, University of Minnesota, Graduate School of Medicine, Mayo Clinic, Rochester, Minn.

Address: "Incidence, Diagnosis and Treatment of the Primary Malignant Tumors of Long Bones."
Dr. Dean D. Lewis, Professor of Surgery, Johns Hopkins University School of Medicine, Baltimore, Md.

Address: "Radiation Therapy in Intra-Oral Cancer with its Complications."
Dr. James M. Martin, Professor of Radiology, Baylor University College of Medicine, Dallas, Tex.

Address: "Infantile Paralysis."
Dr. Wm. McKim Marriott, Dean and Professor of Pediatrics, Washington University School of Medicine, and Physician in Chief, St. Louis Children's Hospital, St. Louis, Mo.

Address: "Etiology and Treatment of Low Back Pain from the Mechanistic (Orthopedic) Point of View."
Dr. Arthur Steindler, Professor of Orthopedic Surgery, State University of Iowa College of Medicine, Iowa City, Iowa.

Address: "Recent Advances in the Treatment of Nephritis."
Dr. James S. McLester, Professor of Medicine, University of Alabama School of Medicine, Birmingham, Alabama.

Wednesday, October 21st

7:30 A. M.

Diagnostic Clinic (Surgical).
Dr. Dean D. Lewis, Professor of Surgery, Johns Hopkins University School of Medicine, Baltimore, Md.

Diagnostic Clinic (Medical).
Dr. Leonard G. Rowntree, Professor of Medicine, University of Minnesota, Graduate School of Medicine, Mayo Clinic, Rochester, Minn.

Diagnostic Clinic (Urological).
Dr. Herman L. Kretschmer, Clinical Professor of Surgery (G.U.), Rush Medical College, Chicago, Ill.

Diagnostic Clinic (Surgical).
Dr. Charles H. Frazier, John Rhea Barton Professor of Surgery, University of Pennsylvania School of Medicine, Philadelphia, Pa.

Intermission for Review of Exhibits

Diagnostic Clinic (Surgical).
Dr. William E. Lower, Cleveland Clinic; Former Associate Professor of Genito-Urinary Surgery, Western Reserve University School of Medicine, Cleveland, Ohio.

Diagnostic Clinic (Surgical).
Dr. Edmond M. Eberts, Professor of Surgery, McGill University Faculty of Medicine, Montreal, Canada.

Address: "The Influence of Pain and Mortality in Modern Medical Practice."
Dr. Charles H. Mayo, Associate Chief of Staff, Mayo Clinic; Professor of Surgery, University of Minnesota Medical School, and University of Minnesota, Graduate School of Medicine, Rochester, Minn.

Noon Intermission

1:00 P. M.

Diagnostic Clinic (Surgical).
Dr. Fred W. Rankin, Associate Professor of Surgery, University of Minnesota, Graduate School of Medicine, Mayo Clinic, Rochester, Minn.

Urology

Address: "Conservative Plastic Procedure in Prostatic Hypertrophy."
Dr. Joseph F. McCarthy, Professor of Urology, New York Post Graduate Medical School, New York, N. Y.

Address: "Further Research Studies of the Factors Which are Conducive to the Production of Prostatic Hypertrophy."
Dr. William E. Lower, Cleveland Clinic; Former Associate Professor of Genito-Urinary Surgery, Western Reserve University School of Medicine, Cleveland, Ohio.

Address: "Treatment of Carcinoma of the Bladder."
Dr. Herman L. Kretschmer, Clinical Professor of Surgery (G.U.), Rush Medical College, Chicago, Ill.

Address: "The Value and Limitations of Intravenous Pyelography in the Diagnosis of Renal and Ureteral Diseases."
Dr. Bernard H. Nichols, Head of the Department of Radiology, Cleveland Clinic, Cleveland, Ohio.

Address: "Diagnosis and Treatment of Tumors of the Testicle."
Dr. Charles C. Higgins, Cleveland Clinic, Cleveland, Ohio.

Intermission for Review of Exhibits

The Central Nervous System

Address: "Experience Gained in One Hundred Operations under Local Anesthetic for the Permanent Cure of Trigeminal Neuralgia Major."
Dr. Wm. T. Coughlin, Professor of Surgery, St. Louis University School of Medicine, St. Louis, Mo.

Address: "Encephalography and Ventriculography —Methods and Interpretation."
Dr. Charles H. Frazier, John Rhea Barton Professor of Surgery, University of Pennsylvania School of Medicine, Philadelphia, Pa.

Address: "Choice of Anesthetic Methods in Different Types of Patients and Conditions."
Dr. John S. Lundy, Associate Professor of Anesthesia, University of Minnesota, Graduate School of Medicine, Mayo Clinic, Rochester, Minn.

Dinner Intermission

7:00 P. M.

Address: "Symptomatology, Prognosis and Treatment of Minor Neuroses and Psychoses."
Dr. Louis J. Karnosh, Assistant Clinical Professor of Nervous Diseases, Western Reserve University School of Medicine, Cleveland, Ohio.

Address: "Pulsating Exophthalmos with Special Reference to Surgical Treatment."
The Joseph Schneider Foundation Presentation.
Dr. John M. Wheeler, Professor of Ophthalmology, Columbia University College of Physicians and Surgeons, New York, N. Y.

Address: "Suggestions from Medical Psychology in the Field of General Medicine."
Dr. Wm. A. White, Professor of Mental and Nervous Diseases, Georgetown University School of Medicine, Washington, D. C.

Address: "Water in Relation to Health and Disease."
Dr. Leonard G. Rowntree, Professor of Medicine, University of Minnesota, Graduate School of Medicine, Mayo Clinic, Rochester, Minn.

Address: "Water and Chemical Balance in Surgery."
Dr. Thomas G. Orr, Professor of Surgery, University of Kansas School of Medicine, Kansas City, Kansas.

Thursday, October 22nd

7:30 A. M.

Diagnostic Clinic (Surgical).
Dr. Waltman Walters, Associate Professor of Surgery, University of Minnesota, Graduate School of Medicine, Mayo Clinic, Rochester, Minn.

Diagnostic Clinic (Medical).
Dr. Russell L. Cecil, Assistant Professor of Clincal Medicine, Cornell University Medical College, New York, N. Y.

Diagnostic Clinic (Pediatric).
Dr. Wm. McKim Marriott, Dean and Professor of Pediatrics, Washington University School of Medicine and Physician in Chief, St. Louis Children's Hospital, St. Louis, Mo.

Diagnostic Clinic (Surgical).
Dr. Arthur Dean Bevan, Clinical Professor of Surgery and Head of the Surgical Department, Rush Medical College, Chicago, Ill.

Intermission for Review of Exhibits

Diagnostic Clinic (Medical).
Dr. Russell L. Haden, Chief of the Medical Staff, Cleveland Clinic, Cleveland, Ohio.

Diagnostic Clinic: "Differentiation of Benign and Malignant Tumors of the Breast."
Dr. Burton J. Lee, Professor of Clinical Surgery, Cornell University Medical College, and Clinical Director of Memorial Hospital, New York, N. Y.

Diagnostic Clinic (Medical).
Dr. James H. Means, Jackson Professor of Clinical Medicine, Harvard University Medical School, and Chief of the Medical Services, Massachusetts General Hospital, Boston, Mass.

Noon Intermission

1:00 P. M.

The Respiratory System

Address: "Roentgenological Diagnosis of Early Tuberculosis."
Dr. B. R. Kirklin, Mayo Clinic, Rochester, Minn.

Address: "Injuries of the Lungs and Pleura."
Dr. Frank K. Boland, Professor of Clinical Surgery, Emory University School of Medicine, Atlanta, Ga.

Address: "Diagnosis and Treatment of Mediastinal Tumors."
Dr. Stuart W. Harrington, Associate Professor of Surgery, University of Minnesota, Graduate School of Medicine, Mayo Clinic, Rochester, Minn.

Address: "Bronchial Obstruction, Partial or Complete, as Shown by the Roentgen Ray Examination."
Dr. Willis F. Manges, Professor of Roentgenology, Jefferson Medical College of Philadelphia, Philadelphia, Pa.

Address: "Abscess of the Lung."
Dr. Carl A. Hedblom, Professor of Surgery, University of Illinois College of Medicine, Chicago, Ill.

Address: "Recent Advances in Diagnosis and Treatment of Pneumonia."
Dr. Russell L. Cecil, Assistant Professor of Clinical Medicine, Cornell University Medical College, New York, N. Y.

Address: "Surgical Treatment of Pulmonary Tuberculosis."
Dr. Alton Ochsner, Professor of Surgery, Tulane University of Louisiana School of Medicine, New Orleans, La.

Intermission for Review of Exhibits

Fractures

Address: "The Treatment of Fractures."
Dr. Melvin S. Henderson, Professor of Orthopedic Surgery, University of Minnesota, Graduate School of Medicine, Mayo Clinic, Rochester, Minn.

Address: "Operative Arrestment of Longitudinal Growth of Bones; Indications for and Results of."
Dr. D. B. Phemister, Professor of Surgery, University of Chicago Medical School, Chicago, Ill.

Address: "The Treatment of Ununited Fractures."
Dr. Edwin W. Ryerson, Professor of Orthopedic Surgery, Northwestern University Medical School, Chicago, Ill.

Address: "Purpura and Pathological Hemorrhage."
Dr. Russell L. Haden, Chief of the Medical Staff, Cleveland Clinic, Cleveland, Ohio.

Dinner Intermission

7:00 P. M.

The Breast

Address: "The Choice and Technic of Surgical Methods in the Treatment of Carcinoma of the Breast."

Dr. Arthur Dean Bevan, Clinical Professor of Surgery and Head of the Surgical Department, Rush Medical College, Chicago, Ill.

Address: "Paget's Disease of the Breast."
Dr. Edmond M. Eberts, Professor of Surgery, McGill University Faculty of Medicine, Montreal, Canada.

Address: "Therapeutic Problems of Syphilis."
Dr. Paul A. O'Leary, Professor of Dermatology, University of Minnesota, Graduate School of Medicine, Mayo Clinic, Rochester, Minn.

Address: "Significance of Hyper- and Hypo- Metabolism."
Dr. James H. Means, Jackson Professor of Clinical Medicine, Harvard University Medical School, and Chief of the Medical Services, Massachusetts General Hospital, Boston, Mass.

Address: "Bright's Disease."
Dr. Hilding Berglund, Professor of Medicine, University of Minnesota Medical School, and University of Minnesota, Graduate School of Medicine, Minneapolis, Minn.

Address: "Some Aspects of Asthma."
Dr. Robert D. Rudolf, Professor of Therapeutics, University of Toronto Faculty of Medicine, Toronto, Canada.

Friday, October 23rd

7:30 A. M.

Diagnostic Clinic (Surgical).
Dr. E. Starr Judd, Professor of Surgery, University of Minnesota, Graduate School of Medicine, Mayo Clinic, Rochester, Minn. President, American Medical Association.

Diagnostic Clinic (Medical).
Dr. John H. Musser, Professor of Medicine, Tulane University of Louisiana School of Medicine, New Orleans, La.

Diagnostic Clinic (Surgical).
Dr. John B. Deaver, Emeritus Professor of Surgery, University of Pennsylvania School of Medicine, and Surgeon-Chief to the Lankenau Hospital, Philadelphia, Pa.

Diagnostic Clinic (Medical).
Dr. Cyrus C. Sturgis, Professor of Internal Medicine, University of Michigan Medical School, Ann Arbor, Michigan.

Intermission for Review of Exhibits

Diagnostic Clinic (Surgical).
Dr. George W. Crile, Cleveland Clinic; Professor Emeritus of Surgery, Western Reserve University School of Medicine, Cleveland, Ohio.

Diagnostic Clinic (Medical).
Dr. Elliott P. Joslin, Clinical Professor of Medicine, Harvard University Medical School, Boston, Mass.

Address: "The Importance of Preserving or Restoring Function in Performing Radical Operations on the Large Intestine and Rectum."
Dr. William J. Mayo, Chief of Staff, Mayo Clinic, Rochester, Minn.
and
Dr. C. F. Dixon, Division of Surgery, Mayo Clinic, Rochester, Minn.

Noon Intermission

1:00 P. M.

Address:
Surgeon-General Hugh S. Cumming, United States Public Health Service, Washington, D. C.

The Gall-Bladder and Liver

Address: "Different Forms of Jaundice and their Significance."
Dr. James E. Paullin, Jr., Professor of Clinical Medicine, Emory University School of Medicine, Atlanta, Ga.

Address: "Malignant Lesions of the Gall-Bladder."
Dr. E . Starr Judd, Professor of Surgery, University of Minnesota, Graduate School of Medicine, Mayo Clinic, Rochester, Minn.

Address: "The Medical Treatment of Gall-Stones and Cholecystitis."
Dr. John H. Musser, Professor of Medicine, Tulane University of Louisiana School of Medicine, New Orleans, La.

Address: "Surgical Aspects of Obstructive Jaundice."
Dr. Waltman Walters, Associate Professor of Surgery, University of Minnesota, Graduate School of Medicine, Mayo Clinic, Rochester, Minn.

Address: "Acute Atrophy of the Liver—Incidence, Pathogenesis, End-Stages."
Dr. M. A. Blankenhorn, Professor of Clinical Medicine, Western Reserve University School of Medicine, Cleveland, Ohio.

Address: "The Functionless Gall-Bladder."
Dr. John B. Deaver, Emeritus Professor of Surgery, University of Pennsylvania School of Medicine, and Surgeon-Chief to the Lankenau Hospital, Philadelphia, Pa.

Intermission for Review of Exhibits

Adress: "Present Aspects .of Treatment of Pernicious Anemia."
Dr. Cyrus C. Sturgis, Professor of Internal Medicine, University of Michigan Medical School, Ann Arbor, Michigan.

Address: "Indications for and Clinical Results in Denervation of the Adrenal Gland."
Dr. George W. Crile, Cleveland Clinic; Professor Emeritus of Surgery, Western Reserve University School of Medicine, Cleveland, Ohio.
and
Dr. E. P. McCullagh, Cleveland Clinic, Cleveland, Ohio.

Address: "Complications and Sequelae of Diabetes."
Dr. Elliott P. Joslin, Clinical Professor of Medicine, Harvard University Medical School, Boston, Mass.

FOREIGN GUESTS

The following is a list of distinguished foreign guests who have tentatively accepted to take part on the program sometime during the Assembly:

Mr. A. A. McConnell, F.R.C.S.I., Chief Surgeon, Richmond Hospital, Dublin, Ireland.

Mr. A. Lawrence Abel, F.R.C.S., Surgeon Cancer Hospital, London, England.

Sir Thomas J. Horder, Bt., London, England.

Dr. Thierry de Martel, Chief Surgeon, American Hospital, Paris, France.

BANQUET

Friday Evening, October 23rd

GRAND BALL ROOM—HOTEL SCHROEDER

Addresses by Distinguished Citizens of the World.

HOTEL HEADQUARTERS

The Hotel Schroeder, located within walking distance of the Auditorium, has been selected as Headquarters Hotel. All guests and officers of the Association will be housed in the Headquarters Hotel.

Adequate first-class facilities have been made

available by Milwaukee hotels to take care of a very large attendance of visiting doctors.

SPECIAL INVITATION TO LADIES

When the Interstate Postgraduate Medical Association of North America meets in Milwaukee, October 19th to the 23rd, it is hoped that the wives and daughters of the attending members will accompany the doctors to our charming city—on Lake Michigan.

The members of the Ladies' Committee have arranged an attractive program for the entertainment of the guests, and it is hoped there will be a large attendance.

The ladies are cordially invited to attend the banquet on Friday evening, October 23rd.

Mrs. Ralph Sproule,
Chairman of the Ladies' Entertainment Committee.

SCIENTIFIC AND TECHNICAL EXHIBIT

The largest exhibit in the history of the Association has been arranged and gathered for the Milwaukee Assembly. It is intended to make the exhibit, as a whole, an important educational feature of the Assembly; exhibiting institutions and firms are cooperating whole heartedly in this respect.

For the Milwaukee Assembly, a very special effort has been made to provide a large scientific exhibit. Thirty-three National, State, and local Institutions and Foundations will participate.

SPECIAL RAILROAD RATES

Special reduced rates on the Certificate plan (fare and one-half for the round trip) have been granted by all the Railroad Passenger Associations of the United States and Canada.

Over 600 Attend Ninetieth Anniversary Meeting at Madison; Dr. Reginald Jackson Selected as President-Elect

Despite a week of extreme heat that broke all records, over 600 members and guests attended the Ninetieth Anniversary Meeting of the State Medical Society at Madison during the four days of September 8th to 11th. With 108 presentations on the scientific program for the three days, at no time was the schedule more than five minutes behind that published in the Journal and program.

Important actions of the House of Delegates during this meeting were:

1. Created a committee to study the subject of distribution of medical service in Wisconsin. This committee will report at the next meeting, September, 1932.

2. Invited the American Medical Association to hold its 1933 meeting in Milwaukee. This is the year of the World's Fair in Chicago and if the invitation is accepted the State Society will forego a scientific session and hold its House of Delegates meetings during the week of the A. M. A. meeting.

3. Authorized the Committee on Public Policy to introduce measures in 1933 placing a physician on county and city health committees; providing for a medical grievance committee, and to remove certain restrictions upon the Governor in making appointments to the Board of Medical Examiners.

4. Authorized the Secretary to confer with those affected in an effort to ascertain whether legislation can be proposed that would provide for inspection and licensing of all institutions that house or care for the sick.

5. Authorized the Society to make such contacts with organizations interested in the public health as will serve to place the informational services of the Society at their disposal when considering legislation.

6. Amended the Constitution to provide life membership in the State Society, contingent upon member maintaining standing in the county society, for those who wish to make outright gifts of $1,000 or more to the Foundation Fund.

7. Amended the by-laws to provide that "No member shall profess adherence or give support to any exclusive dogma, sect, or school."

Dr. Reginald Jackson of Madison was the choice of the House for the office of President-Elect. Dr. Jackson will automatically assume the Presidency following the 1932 meeting. Dr. Stanley J. Seeger, Milwaukee, was elected Speaker of the House of Delegates; Dr. M. D. Bird of Marinette was elected Vice-Speaker of the House, and Milwaukee was chosen as the place of 1932 meeting. Drs. J. F. Smith, Wausau, and M. D. Bird, Marinette, were re-elected as Delegate and Alternate to the A. M. A.

Committee appointments announced by President Otho A. Fiedler of Sheboygan and confirmed by the House follow:

a. Committee on Medical Defense—Dr. Arthur Sullivan of Madison.

b. Committee on Medical Education and Hospitals—Dr. Joseph W. Lambert of Antigo.

c. Committee on Public Policy—Dr. Reginald Jackson of Madison.

d. Committee on Medical Extension—Drs. K. H. Doege of Marshfield and A. J. Wiesender of Berlin.

e. Committee on Medical Economics—Dr. Victor F. Marshall of Appleton.

f. Editorial Board—Dr. Hugh Greeley of Madison.

g. Committee on Health and Public Instruction—Dr. H. M. Stang of Eau Claire.

h. Committee on Scientific Work—Dr. T. L. Squier of Milwaukee. Terms of four of the twelve members of the Council expired at this meeting. Dr. S. E. Gavin, Fond du Lac, was elected from the Sixth District to succeed Dr. F. Gregory Connell of Oshkosh. Drs. Wilson Cunningham, Platteville; C. A. Harper, Madison, and A. H. Heidner of West Bend were elected to succeed themselves.

Notice was also given at this meeting of three amendments to the Constitution which will be considered at the 1932 sessions of the House of Delegates. These are (1) to provide that Councilors shall be members of the House of Delegates but without power of vote, (2) that Councilors shall be elected in the district meetings and (3) to provide for reorganization of the 11th District should that be the consensus of opinion of the counties affected.

Members of the Nominating Committee as selected by the House were: H. P. Bowen, Watertown; F. W. Pope, Racine; J. F. Mauermann, Monroe; E. H. Spiegelberg, Boscobel; R. C. Meyer, Plymouth; J. W. Lockhart, Oshkosh; A. E. Winter, Tomah; A. J. Gates, Tigerton; S. M. B. Smith, Wausau; F. E. Butler, Menomonie; T. J. O'Leary, Superior and H. J. Gramling of Milwaukee.

Appointments to Reference Committees of the House announced by Speaker W. D. Stovall were:

Committee on Credentials:

Dr. C. W. Henney, Portage, Chairman.
Dr. E. P. Crosby, Stevens Point.
Dr. C. F. Peterson, Independence.

Committee on Resolutions:

Dr. Gunnar Gundersen, La Crosse, Chairman.
Dr. S. M. B. Smith, Wausau.
Dr. A. E. Winter, Tomah.
Dr. R. G. Arveson, Frederic.
Dr. H. J. Gramling, Milwaukee.

Committee on Standing Committees:

Dr. C. D. Boyd, Kaukauna, Chairman.
Dr. H. M. Carter, Green Bay.
Dr. F. C. Kinsman, Eau Claire.

Committee on Reports of Officers:

Dr. F. A. Thompson, Milwaukee, Chairman.
Dr. A. J. Wiesender, Berlin.
Dr. E. H. Spiegelberg, Boscobel.

Council Awards Given Drs. Edward Evans, Jermain and McGovern

Opening the general session Thursday evening, in the presence of members, guests and the ladies, Dr. Edward Evans, La Crosse; Dr. Louis F. Jermain, Milwaukee and Dr. John J. McGovern, Milwaukee, were the recipients of the 1931 Council Awards. This award, a gold seal of the Society given as a token of affectionate regard for long years of outstanding service, was inaugurated at the 1930 Annual Meeting. At that session it was presented to Dr. C. A. Harper, Madison and Dr. John M. Dodd of Ashland.

Speaking for the Council, Chairman Arthur W. Rogers of Oconomowoc, made the presentation addresses. These follow in full:

"Mr. President,—My Friends:

"The success that has crowned so many of the public spirited projects of our State Medical Society of Wisconsin since its organization in 1841, and the strong position that we occupy today, has been the result of the work of no one man, nor of the efforts of a few. From as far back in the history of our Society as I can recall, I am impressed by the responsiveness of members and officers alike to their individual duties and needs of their State Society.

"It is true, of course, that certain men by virtue of the responsibilities vested in them by their fellow members, have had larger opportunities for service. Thus a secretary of a county medical society, a councilor or a president may, by his untiring work, leave behind him outstanding accomplishments. We, in Wisconsin, have had large numbers of such men, and as Chairman of the Council I wish to pay to them the respect and appreciation that will ever be theirs from a grateful Society.

"Among this host of contributors to our achievements there stands out, from time to time, one or two who have not only rendered long and exceptional services and discharged their duties faithfully, but have actually given of themselves far beyond the call of office because of the love of the work and the

feeling of satisfaction in doing something more than that required for their Society their brethren in medicine, and the people of this state.

The Council of this Society has taken recognition of these men and from time to time wishes to bestow upon them a little token as small in intrinsic value as it is large as an emblem of the faith, high regard and affection of their fellow members. Tonight I am called upon to give three of these awards,—the gold seal of the society.

The first of these awards this evening is for one who is presently incapacitated as result of his arduous work. In presenting this award I ask his son, Dr. Edward T. Evans of Minneapolis, to rise and receive the award for his Father—

Edward Evans

Born in Ontario, a practicing physician of La Crosse since 1888, Regent of the University of Wisconsin from 1902 to 1913, Councilor for twenty-two years and Chairman of the Council for twelve years, President of our Society in 1909, Associate Editor of "Hospital Progress"; for your life of devotion to the betterment of the profession you love, for your years in the public service and for your inspiring leadership in attaining the highest ideals of medicine, we, your fellow members, give you this seal of our Society as a token of your achievements and our esteem and affection.

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Louis Francis Jermain

A son of Wisconsin, resident of Milwaukee since 1894, Assistant Health Commissioner from 1896 to 1910, Professor of the Wisconsin College of Physicians and Surgeons from 1894 to 1912, Dean of Marquette University School of Medicine from 1913 to 1926 and presently its Emeritus Dean, President of the Medical Society of Milwaukee County in 1910, President of the Milwaukee Academy of Medicine in 1912 and of our Society in 1915; for your efforts which culminated in the establishment of Marquette University School of Medicine, for your outstanding pioneer services as educator and Dean and for your life work in the joint interest of the public and our profession, we, your fellow members, give you this seal of our Society as a token of your achievements and our esteem and affection.

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John Joseph McGovern

A son of Wisconsin, practitioner of medicine in Milwaukee since 1893, educator from 1894 to 1899, chairman and member of county and state committees on public policy and legislation, President of the Medical Society of Milwaukee County in 1912 and President of our Society in 1928; for your indomitable courage and efforts to which we owe our first legislation of 1897 governing the practice of medicine in this State, for your untiring interest in its constant perfection culminating in your work that so largely made possible the passage of the Basic Science Act of 1925, for your great contributions in time and interest at a period when our Society was without its cohesive whole of today, and for your visions of proper health legislation which you made true by persistent effort, we, your fellow members, give you this seal of our Society as a token of your achievements and of our esteem and affection.

Dr. J. E. Rueth, Milwaukee, Wins in Golf Tournament

Dr. J. E. Rueth, Milwaukee, led a field of almost fifty golfers in the annual tournament of the State Medical Society of Wisconsin at Maple Bluff Country Club, September 8th, held in connection with the 90th anniversary meeting. His score of 38–40–78 won the President's Cup for him.

Low net for the 18 holes was tied for by Dr. F. A. Thayer, Beloit, and Dr. G. A. Sullivan, Milwaukee, both having 71s. They will share the Secretary's Cup during the year, each holding it for six months.

Low net for the first nine was also won by Dr. Sullivan with a 32, while Dr. A. J. Raymond, Milwaukee, took second with 33.

Dr. Thayer's 35 was low net for the sec-

ond nine, while Dr. J. K. Chorlog, Madison, Dr. George V. Lynch, Oshkosh, Dr. R. C. Meyer, Plymouth, and Dr. J. D. Wilkinson, Oconomowoc, tied for second with 36s.

A net score of 77 won the blind bogey, with Dr. V. B. Hyslop, Madison, Dr. J. K. Trumbo, Wausau, and Dr. S. G. Higgins, Milwaukee, tied at that score. No one went as high as 8, the blind bogey for the sixth hole, but Dr. R. C. Meyer, Plymouth, and Dr. O. E. Satter, Prairie du Chien, tied with 7s.

Dr. Albert R. Tormey, Madison, was chairman of this year's golf tournament.

PRIZES AWARDED

President's Cup: Dr. J. E. Rueth, Milwaukee. Low gross score 78. A silver cocktail mixer for permanent possession.

Secretary's Cup: Dr. G. A. Sullivan, Milwaukee, and Dr. F. A. Thayer, Beloit. Low net score resulted in a tie with 71. Silver ice pail for permanent possession.

Low gross first 9 holes: Dr. F. J. Schubert, Milwaukee—40. Silver combination spoon.

Low net on first 9 holes: Won by Dr. A. J. Raymond, Milwaukee—33. Silver combination spoon.

Low gross second 9 holes: Dr. Mark Bach, Milwaukee—40. Silver combination spoon.

Low net on second 9 holes: Drs. J. K. Chorlog, Geo. V. Lynch, R. C. Meyer, and J. D. Wilkinson, resulted in a tie with 36. Won on draw by Dr. J. D. Wilkinson. Silver combination spoon.

Blind bogey resulted in a tie between Dr. J. K. Trumbo, Wausau, and Dr. S. G. Higgins, Milwaukee —77. Dr. J. K. Trumbo won the tie. Heavy Country Club Coat.

Blind Hole No. 6: Won by Dr. V. B. Hyslop, Madison, with 8 strokes. Putter.

Sixteen "Birdies" were made as follows:

1.	Dr. E. F. Schneiders	1
2.	Dr. A. Jackson	1
3.	Dr. E. W. Miller	1
4.	Dr. R. E. Fitzgerald	1
5.	Dr. M. Bach	2
6.	Dr. F. E. Brinckerhoff	2
7.	Dr. O. E. Satter	2
8.	Dr. M. E. Ross	1
9.	Dr. J. E. Rueth	1
10.	Dr. E. Bach	2
11.	Dr. E. M. Juster	1
12.	Dr. G. R. Love	1

A golf ball was given for each "Birdie".

Low score on 4 short holes:

1.	Dr. F. E. Brinckerhoff, Beloit	15
2.	Dr. R. H. Jackson, Madison	15
3.	Dr. J. E. Rueth, Milwaukee	15
4.	Dr. J. K. Chorlog, Madison	15
5.	Dr. H. B. Hitz, Milwaukee	15

The tie was won by Dr. F. E. Brinckerhoff, Beloit. One-half dozen golf balls.

Low score on 4 long holes:

1.	Dr. E. W. Miller, Milwaukee	20

One-half dozen golf balls.

List of Registrants at 90th Anniversary Meeting

Members—512

Allen, Jessie P. ---Beloit
Allen, J. S. ---Norwalk
Allen, S. C. ---Waterloo
Allen, W. J. ---Beloit
Alvarez, R. L. ---Galesville
Amundson, Karl K. ---Cambridge
Andrew, C. H. ---Platteville
Armstrong, C. A. ---Prairie du Chien
Arveson, R. G. ---Frederic
Axley, A. A. ---Washburn

Bach, Mark J. ---Milwaukee
Bannen, W. E. ---La Crosse
Bardeen, C. R. ---Madison
Barnes, H. T. ---Delafield
Bartels, G. W. ---Janesville
Bassuener, R. O. ---Sheboygan
Becker, W. C. ---Watertown
Beebe, C. D. ---Sparta
Beebe, S. D. ---Sparta
Belting, G. W. ---Orfordville
Benn, H. P. ---Stevens Point
Bennett, J. F. ---Burlington
Benson, Gideon H. ---Richland Center
Benton, R. W. ---Whitefish Bay
Bertrand, J. H. ---De Forest
Bickel, E. F. ---Oshkosh
Bill, B. J. ---Genoa City
Bilstad, G. E. ---Cambridge
Bird, M. D. ---Marinette
Birnbaum, F. A. ---Marathon
Bitter, R. H. ---Oshkosh
Blackburn, F. E. ---Cassville
Blair, J. F. ---Milwaukee
Blankinship, R. C. ---Madison
Bleckwenn, W. J. ---Madison
Blekking, J. H. ---Sheboygan Falls
Blewett, M. T. ---Markesan
Blumenthal, R. W. ---Milwaukee
Bolton, E. L. ---Appleton
Blount, W. P. ---Milwaukee
Boner, A. J. ---Madison
Borman, M. C. ---Milwaukee
Borsack, K. K. ---Fond du Lac
Boslough, A. W. ---Wausau
Bowen, H. P. ---Watertown
Bowman, F. F. ---Madison
Boyd, C. D. ---Kaukauna
Boyd, G. T. ---Fond du Lac
Boynton, R. D. ---Wisconsin Dells
Brehm, H. G. ---Racine
Brindley, B. I. ---Madison
Brook, J. J. ---Milwaukee
Brown, G. V. I. ---Milwaukee
Bryan, A. W. ---Madison
Buckner, H. M. ---Mt. Horeb
Buerki, R. C. ---Madison
Bunting, C. H. ---Madison

Burns, R. E. ---------- Madison
Busse, A. A. ---------- Jefferson
Butler, F. E. ---------- Menomonie

Cairns, Rolla ---------- River Falls
Caldwell, H. M. ---------- Columbus
Calvert, Charlotte ---------- Madison
Campbell, W. B. ---------- Waukesha
Cantwell, R. C. ---------- Shawano
Caples, B. M. ---------- Waukesha
Carhart, G. A. ---------- Milwaukee
Carson, W. J. ---------- Milwaukee
Carter, H. M. ---------- Madison
Carter, R. M. ---------- Green Bay
Cary, E. C. ---------- Reedsville
Cassels, G. S. ---------- Pt. Washington
Chandler, J. ---------- Pardeeville
Chorlog, J. K. ---------- Madison
Christensen, F. C. ---------- Racine
Christensen, H. H. ---------- Wausau
Christofferson, H. H. ---------- Colby
Clark, F. T. ---------- Waupun
Clarke, T. C. ---------- Milwaukee
Coffey, C. J. ---------- Milwaukee
Coluccy, M. J. J. ---------- Madison
Comee, W. C. ---------- Green Bay
Comstock, Elizabeth ---------- Arcadia
Connell, F. Gregory ---------- Oshkosh
Constantine, C. ---------- Racine
Conway, H. P. ---------- Spring Valley
Coon, H. M. ---------- Stevens Point
Costello, W. H. ---------- Randolph
Cox, A. M. ---------- Albany
Crone, V. D. ---------- Beloit
Crosby, E. P. ---------- Stevens Point
Crosley, G. E. ---------- Milton
Crowe, N. F. ---------- Delavan
Cunningham, Wilson ---------- Platteville
Currer, P. M. ---------- Milwaukee
Cushing-Lippitt, Eléanore ---------- Milwaukee

Darby, G. S. ---------- Brodhead
Davies, R. E. ---------- Waukesha
Davis, F. A. ---------- Madison
Davis, Helen P. ---------- Madison
Dean, James P. ---------- Madison
Dean, Joseph ---------- Madison
Deicher, H. F. ---------- Plymouth
Delaney, H. O. ---------- Beloit
de Neveu, A. V. ---------- Milwaukee
Dennis, J. F. ---------- Waterloo
Devine, G. C. ---------- Ontario
Dierker, O. F. ---------- Watertown
Dieterle, J. O. ---------- Milwaukee
Dillman, A. E. ---------- Steuben
Dockry, L. E. ---------- Kewaunee
Dodd, J. M. ---------- Ashland
Doege, K. H. ---------- Marshfield
Doege, K. W. ---------- Marshfield
Doege, P. F. ---------- Marshfield
Domine, A. Z. ---------- Black River Falls
Doolittle, J. C. ---------- Lancaster
Dougherty, J. S. ---------- Suring
Doyle, J. N. ---------- Wausau
Duer, G. R. ---------- Marinette
Dull, C. F. ---------- Richland Center
Dunn, E. A. A. ---------- Platteville

Ebert, R. O. ---------- Oshkosh
Echols, C. M. ---------- Milwaukee
Edwards, W. C. ---------- Richland Center
Egan, W. J. ---------- Milwaukee
Eisenberg, P. J. ---------- Milwaukee
Elliott, E. S. ---------- Fox Lake
Elsom, J. C. ---------- Madison
Enzer, Norbert ---------- Milwaukee

Epley, O. H. ---------- New Richmond
Ewell, G. H. ---------- Madison

Federman, E. H. ---------- Montello
Fehland, H. R. ---------- Wausau
Festerling, E. G. ---------- Milwaukee
Fiebiger, G. J. ---------- Waterloo
Fiedler, O. A. ---------- Sheboygan
Fillbach, H. E. ---------- Hazel Green
Finn, W. C. ---------- Fond du Lac
Fisher, R. F. ---------- Wausau
Fitzgerald, R. E. ---------- Milwaukee
Flarity, T. H. ---------- Beloit
Fletcher, Wm. ---------- Salem
Florin, A. C. ---------- Fond du Lac
Focke, W. J. ---------- Poynette
Foley, F. P. ---------- Dorchester
Fowler, J. H. ---------- Lancaster
Fox, Paul A. ---------- Beloit
Francois, S. J. ---------- New Glarus
Frederick, H. Y. ---------- Westfield
Freeman, J. M. ---------- Wausau
Frenzel, W. C. ---------- Wausau
Frisbie, R. L. ---------- Rhinelander
Froggatt, W. E. L. ---------- Cross Plains

Gaenslen, F. J. ---------- Milwaukee
Gale, J. W. ---------- Madison
Gallaher, D. M. ---------- Appleton
Ganser, W. J. ---------- Madison
Garvey, J. L. ---------- Milwaukee
Gates, A. J. ---------- Tigerton
Gavin, S. E. ---------- Fond du Lac
Geist, F. D. ---------- Madison
Gillette, H. E. ---------- Pardeeville
Glasier, M. B. ---------- Bloomington
Gleason, C. M. ---------- Manitowoc
Gnagi, W. B., Jr. ---------- Monroe
Goedecke, R. H. ---------- West Salem
Gonce, J. E. ---------- Madison
Gorder, A. C. ---------- Milwaukee
Gosin, F. J. ---------- Green Bay
Gramling, E. H. ---------- Milwaukee
Gramling, H. J. ---------- Milwaukee
Gray, R. J. ---------- Brooklyn
Greeley, H. P. ---------- Madison
Gregory, A. T. ---------- Mauston
Gudex, V. A. ---------- Milwaukee
Guilford, H. M. ---------- Madison
Guilfoyle, J. P. ---------- Evansville
Gundersen, G. ---------- La Crosse

Haberland, E. J. ---------- Milwaukee
Halsey, W. H. ---------- Milwaukee
Hansberry, P. H. ---------- Hillsboro
Hansen, John ---------- Glenbeulah
Harkins, J. P. ---------- Madison
Harper, Carl S. ---------- Madison
Harrington, T. L. ---------- Milwaukee
Harris, J. W. ---------- Madison
Hartman, R. C. ---------- Janesville
Harvey, J. R. ---------- Footville
Hassall, J. C. ---------- Oconomowoc
Hatleberg, C. B. ---------- Chippewa Falls
Head, L. R. ---------- Madison
Heiden, H. H. ---------- Sheboygan
Heidner, A. H. ---------- West Bend
Henika, G. W. ---------- Madison
Henney, C. W. ---------- Portage
Herner, W. L. ---------- Milwaukee
Higgins, S. G. ---------- Milwaukee
Hildebrand, G. J. ---------- Sheboygan
Hitz, H. B. ---------- Milwaukee
Hodgson, A. J. ---------- Waukesha
Howard, M. Q. ---------- Wauwatosa
Hoyer, A. A. ---------- Beaver Dam
Hoyt, G. E. ---------- Milwaukee

Hudson, L. A. ---------- Sauk City
Hugo, D. G. ---------- Oshkosh
Hurlbut, J. A. ---------- Madison
Huston, John ---------- Milwaukee
Hyslop, V. B. ---------- Madison

Irwin, H. J. ---------- Baraboo

Jackson, Arnold ---------- Madison
Jackson, R. H. ---------- Madison
Jacobson, T. L. ---------- Delavan
Jamieson, G. H. ---------- Racine
Jamieson, R. D. ---------- Racine
Jegi, H. A. ---------- Galesville
Jermain, L. F. ---------- Milwaukee
Jermain, W. M. ---------- Milwaukee
Johnson, F. G. ---------- Iron River
Johnson, H. Curtis ---------- Madison
Johnson, J. M. ---------- Ripon
Johnston, T. L. ---------- Milwaukee
Johnston, W. M. ---------- Johnson Creek
Joseph, W. A. ---------- Milwaukee

Karnopp, G. L. ---------- Wautoma
Karsten, J. H. ---------- Horicon
Kassowitz, K. E. ---------- Wauwatosa
Kastner, A. L. ---------- Milwaukee
Kauth, P. M. ---------- Slinger
Kay, H. M. ---------- Madison
Keland, H. B. ---------- Racine
Kidder, E. E. ---------- Stevens Point
King, J. M. ---------- Milwaukee
Kinsman, F. T. ---------- Eau Claire
Knauf, N. J. ---------- Chilton
Kosanke, F. E. ---------- Fond du Lac
Kristjanson, H. T. ---------- Milwaukee
Krueger, B. ---------- Cudahy
Kuegle, F. H. ---------- Janesville
Kurten, R. M. ---------- Racine
Kurtz, C. M. ---------- Madison

Ladewig, H. C. ---------- Milwaukee
Lapp, H. D. ---------- Janesville
Leahy, J. D. ---------- Park Falls
Lee, J. H. ---------- Madison
Leeson, F. W. ---------- Beloit
Leicht, Phillip ---------- Lake Mills
Leitzell, P. W. ---------- Benton
Liefert, W. C. ---------- Milwaukee
Light, George ---------- Milwaukee
Lindner, A. M. ---------- Racine
Lindsay, W. T. ---------- Madison
Littig, L. V. ---------- Madison
Lockhart, J. W. ---------- Oshkosh
Longley, J. R. ---------- Fond du Lac
Lorenz, W. F. ---------- Madison
Lotz, Oscar ---------- Milwaukee
Lowe, J. W. ---------- Merrillan
Ludden, H. D. ---------- Mineral Point
Ludden, R. H. ---------- Viroqua
Lynch, D. W., Jr. ---------- Milwaukee
Lynch, G. V. ---------- Oshkosh
Lynch, H. M. ---------- Milwaukee

Maas, W. C. ---------- Rio
Macaulay, E. M. ---------- Wausau
Mac Arthur, D. S. ---------- La Crosse
Mac Cornack, R. L. ---------- Whitehall
Mac Innis, F. E. ---------- Milwaukee
Mac Laren, J. B. ---------- Appleton
Madison, F. W. ---------- Milwaukee
Majerus, P. J. ---------- Ft. Atkinson
Marek, F. B. ---------- Racine
Marsh, H. E. ---------- Madison
Marshall, V. F. ---------- Appleton
Mason, E. L. ---------- Eau Claire
Mauel, N. M. ---------- Cashton
Mauermann, J. F. ---------- Monroe

McCabe, J. M. ---------- Sun Prairie
McCann, Edith ---------- Milwaukee
McCarthy, J. J. ---------- Sun Prairie
McDowell, A. J. ---------- Soldiers Grove
McGary, Lester ---------- Madison
McGovern, J. J. ---------- Milwaukee
McGrath, Edward ---------- Baraboo
McMahon, A. E. ---------- Glenwood City
McMahon, F. B. ---------- Milwaukee
McMahon, H. O. ---------- Milwaukee
McQuillin, E. D. ---------- New Glarus
Meade, F. S. ---------- Madison
Meany, S. G. ---------- East Troy
Merrill, W. G. ---------- Wisconsin Rapids
Meusel, H. H. ---------- Oshkosh
Meyer, R. C. ---------- Plymouth
Middleton, W. S. ---------- Madison
Midelfart, H. C. ---------- Eau Claire
Millard, A. L. ---------- Appleton
Miller, E. W. ---------- Milwaukee
Miller, W. J. ---------- Madison
Miller, William Snow ---------- Madison
Mills, R. G. ---------- Fond du Lac
Mitchell, E. J. ---------- Brodhead
Mitchell, F. W. ---------- Medford
Mitchell, R. E. ---------- Eau Claire
Moe, H. B. ---------- Janesville
Monsted, J. W., Jr. ---------- New London
Montgomery, R. B. ---------- La Valle
Montgomery, R. C. ---------- Madison
Morris, S. I. ---------- Madison
Mowry, W. A. ---------- Madison
Mudroch, J. A. ---------- Columbus
Mueller, G. G. ---------- Princeton
Mueller, W. E. ---------- Green Bay
Mullen, R. A. ---------- East Troy
Mundt, Raymond ---------- Oconomowoc
Murphy, F. D. ---------- Milwaukee
Myers, C. E. ---------- North Freedom

Nammacher, T. H. ---------- Oconomowoc
Nause, F. A. ---------- Sheboygan
Nauth, D. F. ---------- Kiel
Nee, Frank ---------- Spring Green
Neff, E. E. ---------- Madison
Neilson, G. W. ---------- Milwaukee
Nesbit, Mark ---------- Madison
Neupert, C. N. ---------- Janesville
Nichols, W. T. ---------- Milwaukee
Nixon, H. G. B. ---------- Hartland
Noble, J. B. ---------- Waukesha
Noer, R. J. ---------- Wabeno
Notbohm, W. R. ---------- Sullivan
Nuzum, T. W. ---------- Janesville

Ohlsen, M. P. ---------- Monticello
O'Leary, T. J. ---------- Superior
Oliver, J. B. ---------- Ripon
Oliver, L. H. ---------- Waupun
Oliver, T. J. ---------- Green Bay
Olson, H. J. ---------- Milwaukee
O'Neal, O. ---------- Ripon
Osgood, C. W. ---------- Milwaukee

Parke, George ---------- Viola
Patek, A. J. ---------- Milwaukee
Paul, Francis ---------- Madison
Peterman, M. G. ---------- Milwaukee
Peters, H. A. ---------- Oconomowoc
Peterson, C. F. ---------- Independence
Peterson, L. W. ---------- Shawano
Peterson, L. W. ---------- Sun Prairie
Pfefferkorn, E. B. ---------- Oshkosh
Pfeifer, E. C. ---------- Racine
Pfisterer, F. W. ---------- Markesan
Pink, J. J. ---------- Milwaukee
Pitz, M. N. ---------- Neenah

Pleyte, A. A. ---------- Milwaukee
Pomainville, G. J. ---------- Nekoosa
Pope, F. W. ---------- Racine
Popp, Albert ---------- Milwaukee
Poser, E. M. ---------- Columbus
Potter, R. P. ---------- Marshfield
Powers, H. W. ---------- Milwaukee
Powers, J. W. ---------- Milwaukee
Pratt, G. N. ---------- Neenah
Prentice, J. W. ---------- Ashland
Prince, L. H. ---------- Waukesha
Puestow, K. L. ---------- Madison
Purcell, H. E. ---------- Madison

Quisling, Sverre ---------- Madison

Radloff, A. C. ---------- Plymouth
Raine, Forrester ---------- Milwaukee
Ravn, E. O. ---------- Merrill
Raymond, R. G. ---------- Brownsville
Reagles, R. ---------- Arlington
Redelings, T. J. ---------- Marinette
Reese, William ---------- Dodgeville
Rehorst, J. J. ---------- Fond du Lac
Reineking, W. C. ---------- Madison
Remer, W. H. ---------- Chaseburg
Reynolds, Bertha ---------- Lone Rock
Ridley, S. R. ---------- Mineral Point
Ries, T. O. ---------- Luck
Riopelle, W. G. ---------- Beaver Dam
Ripley, H. M. ---------- Kenosha
Ritchie, G. ---------- Madison
Ritchie, G. A. ---------- Appleton
Robbins, J. H. ---------- Madison
Roethke, R. W. ---------- Milwaukee
Rogers, A. W. ---------- Oconomowoc
Rosenheimer, A. M. ---------- Beaver Dam
Ross, M. E. ---------- Brodhead
Ruehlman, D. D. ---------- Monroe
Ruka, E. A. ---------- Muscoda
Ryan, E. S. ---------- Sheboygan

Satter, O. E. ---------- Prairie du Chien
Sattre, O. M. ---------- Rice Lake
Sauthoff, A. ---------- Mendota
Schacht, R. J. ---------- Racine
Schaefer, C. O. ---------- Racine
Schiek, I. E. ---------- Rhinelander
Schlaepfer, K. ---------- Milwaukee
Schlegel, H. T. ---------- Wausau
Schloemer, A. J. ---------- Jackson
Schmeling, A. F. ---------- Columbus
Schmidt, E. R. ---------- Madison
Schneider, C. C. ---------- Milwaukee
Schneiders, E. F. ---------- Madison
Schodron, R. C. ---------- Milwaukee
Schulz, H. A. ---------- Edgar
Schumm, H. C. ---------- Milwaukee
Scott, B. E. ---------- Berlin
Scullard, Garner ---------- Eau Claire
Seaman, G. E. ---------- Milwaukee
Senn, C. U. ---------- Ripon
Sevringhaus, E. L. ---------- Madison
Sexton, W. G. ---------- Marshfield
Shapiro, H. ---------- Friendship
Sharpe, H. A. ---------- Verona
Sharpe, H. R. ---------- Fond du Lac
Shaw, B. W. ---------- Waunakee
Sheldon, W. H. ---------- Madison
Shepard, E. L. ---------- Brandon
Sieker, A. W. ---------- Plymouth
Sinaiko, A. A. ---------- Stevens Point
Sincock, H. A. ---------- Superior
Sisk, I. R. ---------- Madison
Sisk, J. N. ---------- Madison
Skemp, A. A. ---------- La Crosse
Slaney, A. F. ---------- Hilbert
Slaney, J. G. ---------- Milwaukee
Sleyster, Rock ---------- Wauwatosa
Smiles, C. J. ---------- Ashland
Smith, H. S. ---------- Cudahy
Smith, Joseph F. ---------- Wausau
Smith, S. M. B. ---------- Wausau
Snodgrass, T. J. ---------- Janesville
Spelbring, P. G. ---------- Eau Claire
Spiegelberg, E. H. ---------- Boscobel
Spitz, M. M. ---------- Milwaukee
Sprague, L. V. ---------- Madison
Squier, T. L. ---------- Milwaukee
Stang, H. M. ---------- Eau Claire
Stannard, G. H. ---------- Sheboygan
Stebbins, G. G. ---------- Madison
Stebbins, W. W. ---------- Madison
Stoddard, C. H. ---------- Milwaukee
Stovall, W. D. ---------- Madison
Stratton, F. A. ---------- Milwaukee
Studley, W. H. ---------- Milwaukee
Sullivan, A. G. ---------- Madison
Sullivan, E. S. ---------- Madison
Supernaw, J. S. ---------- Madison
Swartz, K. A. ---------- Waupun

Tasche, L. W. ---------- Sheboygan
Tasche, J. C. ---------- Sheboygan
Taylor, A. R. ---------- Brodhead
Taylor, J. Gurney ---------- Milwaukee
Thackeray, R. C. ---------- Racine
Thayer, F. A. ---------- Beloit
Thompson, A. S. ---------- Mt. Horeb
Thompson, F. A. ---------- Milwaukee
Thornton, M. J. ---------- Madison
Tierney, E. F. ---------- Portage
Tippett, W. P. ---------- Green Bay
Tolan, T. L. ---------- Milwaukee
Tormey, A. R. ---------- Madison
Towne, W. H. ---------- Hortonville
Townsend, E. H. ---------- La Crosse
Townsend, E. J. ---------- Madison
Treadwell, G. F. ---------- Friendship
Trowbridge, C. H. ---------- Viroqua
Trumbo, J. K. ---------- Wausau
Tufts, Millard ---------- Milwaukee
Turkeltaub, S. M. ---------- Milwaukee

Van Valzah, R. ---------- Madison
Van Zanten, W. W. ---------- Sheboygan
Vedder, J. B. ---------- Marshfield
Venning, J. R. ---------- Ft. Atkinson
Vingom, C. O. ---------- Madison
Vogel, C. C. ---------- Elroy
Vogel, T. L. ---------- Milton Junction
von Neupert, C. ---------- Stevens Point

Wahl, C. M. ---------- Spring Green
Waite, W. S. ---------- Watertown
Walker, H. M. ---------- Dodgeville
Walters, D. N. ---------- Fond du Lac
Warfield, L. M. ---------- Milwaukee
Washburne, A. C. ---------- Madison
Waters, R. M. ---------- Madison
Wear, J. B. ---------- Madison
Webb, E. P. ---------- Beaver Dam
Webb, H. E. ---------- Milwaukee
Weber, A. J. ---------- Milwaukee
Wegmann, N. J. ---------- Milwaukee
Weiland, H. P. ---------- Madison
Welke, E. G. ---------- Madison
Wenstrand, D. E. W. ---------- Milwaukee
Werner, C. F. ---------- St. Cloud
Werner, H. C. ---------- Mendota
Werner, Nels ---------- Eau Claire
Werrell, W. A. ---------- Madison
Weston, F. L. ---------- Madison
Wheeler, R. ---------- Madison
Wiley, F. S. ---------- Fond du Lac

Wilkinson, J. D. ---------- Oconomowoc
Wilkinson, J. F. ---------- Oconomowoc
Williams, W. B. ---------- Argyle
Williamson, C. S. ---------- Green Bay
Wilson, O. M. ---------- Wausau
Wing, W. S. ---------- Oconomowoc
Winter, A. E. ---------- Tomah
Wirig, M. H. ---------- Madison
Witte, D. H. ---------- Milwaukee
Wochos, W. M. ---------- Kewaunee
Wright, J. C. ---------- Antigo

Yockey, J. C. ---------- Fond du Lac

Zintek, S. S. ---------- Milwaukee

Guests—105

Black, Nelson M. ---------- Miami, Fla.
Smith, H. F. ---------- Brillion
Nelson, M. H. ---------- Madison
Taylor, E. A. ---------- Madison
Conwell, H. Earle ---------- Birmingham, Ala.
Mannis, Harry ---------- Madison
Brillman, Charles ---------- Milwaukee
Brunkow, Ben ---------- Janesville
Phillips, C. M. ---------- Madison
Freitag, S. A. ---------- Janesville
Shapiro, Herman H. ---------- Madison
Wien, Irving A. ---------- Madison
Wood, C. A. ---------- Waukesha
Rector, F. L. ---------- Evanston, Ill.
Wegman, G. H. ---------- Madison
Caldwell, D. M. ---------- Madison
Springberg, J. C. ---------- Madison
Maresh, Frank ---------- Madison
Fechtner, H. H. ---------- Madison
Greene, H. L. ---------- Madison
Bitter, H. ---------- Milwaukee
Parker, P. ---------- Oshkosh
Bishop, H. F. ---------- Madison
Braasch, W. F. ---------- Rochester, Minn.
Culver, H. B. ---------- Chicago, Ill.
Bumpus, H. C. ---------- Rochester, Minn.
Hoel, K. P. ---------- Kansas City, Mo.
Midelfart, C. F. ---------- Eau Claire
Cummings, Earl F. ---------- Madison
Meier, H. J. ---------- Burlington
Benedict, W. L. ---------- Rochester, Minn.
Dryer, R. B. ---------- Morrisonville
Shinbach, C. C. ---------- Madison
Miller, M. G. ---------- Madison
Faber, C. ---------- Milwaukee
Schmallenberg, H. H. ---------- New London
Egdahl, A. ---------- Rockford, Ill.
Christenson, A. W. ---------- Rockford, Ill.
Smedal, A. T. ---------- Madison
Aaberg, M. E. ---------- Chicago, Ill.
Vedder, C. A. ---------- Chicago, Ill.
Gullard, E. G. ---------- Madison
Stadel, Ernest ---------- Madison
Welker, Wm. H. ---------- Chicago, Ill.
Lee, H. J. ---------- Madison
Leonard, T. A. ---------- Madison
Hutter, A. M. ---------- Madison
Overton, J. B. ---------- Madison
Aageson, C. W. ---------- Madison
Bryant, W. V. ---------- Madison
John, G. W. ---------- Beloit
Krehl, Wm. H. ---------- Madison
Broberg, Gail R. ---------- Blue Earth, Minn.
Cole, L. R. ---------- Milwaukee
Passolacqua, C. ---------- Madison
Cutler, M. ---------- Chicago, Ill.
Bloodgood, J. C. ---------- Baltimore, Md.
Campbell, P. ---------- Waukesha
Poque, Mary E. ---------- Wheaton, Ill.
Tax, A. H. ---------- Madison
Hoffman, J. S. ---------- Madison
Dollard, J. E. ---------- Madison
Bayley, W. E. ---------- Madison
Gallistel, E. ---------- Madison
Goodnight, F. ---------- Madison
Backe, Irma ---------- Kenyon, Minn.
Berggren, J. R. ---------- New Richmond
Hipke, M. M. ---------- Milwaukee
Schmidhofer, Max ---------- Chicago, Ill.
Stuessey, M. F. ---------- Blanchardville
Donovan, Anthony ---------- Madison
Pawlisch, O. V. ---------- Reedsburg
Bulley, K. G. ---------- Milwaukee
Teline, Max ---------- Milwaukee
Shang, Geneva ---------- Milwaukee
Zintek, Arthur ---------- Milwaukee
Von Neupert, Otto ---------- Stevens Point
Pomainville, Harold ---------- Nekoosa
Kenney, H. J. ---------- Delavan
Mayo, Chas. W. ---------- Rochester, Minn.
Pollock, S. K. ---------- Wauwatosa
Kasak, Michael ---------- Wauwatosa
Grossman, L. L. ---------- Milwaukee
Fox, M. S. ---------- Milwaukee
Wilets, J. C. ---------- Milwaukee
McPheeters, H. O. ---------- Minneapolis, Minn.
Kirklin, B. R. ---------- Rochester, Minn.
Kennedy, F. H. ---------- Waterloo
Thayer, R. ---------- Beloit
Tjoflat, O. E. ---------- St. Louis, Mo.
Light, C. E. ---------- Madison
Moxon, G. ---------- Milwaukee
Langan, P. ---------- Milwaukee
Williams, B. ---------- Oshkosh
Dickelmann, L. E. ---------- Oshkosh
McCarty, R. T. ---------- Kaukauna
Beye, H. L. ---------- Iowa City, Ia.
Crowell, B. C. ---------- Chicago, Ill.
Curtis, A. H. ---------- Chicago, Ill.
Fogelson, S. J. ---------- Chicago, Ill.
Henderson, M. S. ---------- Rochester, Minn.
Lewis, Dean ---------- Baltimore, Md.
McClure, R. D. ---------- Detroit, Mich.
New, Gordon B. ---------- Rochester, Minn.
Rankin, F. W. ---------- Rochester, Minn.

Woman's Auxiliary—64

Mrs. H. H. Christofferson ---------- Colby
Mrs. H. J. Gramling ---------- Milwaukee
Mrs. James Blake ---------- Hopkins, Minn.
Mrs. A. H. Heidner ---------- West Bend
Mrs. Gideon Benson ---------- Richland Center
Mrs. J. H. Bertrand ---------- De Forest
Mrs. J. M. Johnson ---------- Ripon
Mrs. C. U. Senn ---------- Ripon
Mrs. J. R. Longley ---------- Fond du Lac
Mrs. J. R. Venning ---------- Fort Atkinson
Mrs. K. K. Amundson ---------- Cambridge
Mrs. C. M. Gleason ---------- Manitowoc
Mrs. J. S. Dougherty ---------- Suring
Mrs. B. E. Scott ---------- Berlin
Mrs. E. H. Federman ---------- Montello
Mrs. E. C. Pfeifer ---------- Racine
Mrs. H. Shapiro ---------- Friendship
Mrs. Wm. Liefert ---------- Milwaukee
Mrs. C. R. Bardeen ---------- Madison
Mrs. J. J. McGovern ---------- Milwaukee
Mrs. George Neilson ---------- Milwaukee
Mrs. K. W. Doege ---------- Marshfield
Mrs. C. A. Harper ---------- Madison
Mrs. W. H. Towne ---------- Hortonville
Mrs. E. L. Bolton ---------- Appleton
Mrs. Ray Blankinship ---------- Madison
Mrs. E. R. Schmidt ---------- Madison
Mrs. W. D. Stovall ---------- Madison
Mrs. J. H. Robbins ---------- Madison

Mrs. Gorton Ritchie ----------Madison
Mrs. O. M. Sattre ----------Rice Lake
Mrs. Frank W. Kuehl ----------Madison
Mrs. H. M. Ripley ----------Kenosha
Mrs. M. D. Bird ----------Marinette
Mrs. T. W. Tormey ----------Madison
Mrs. Albert Tormey ----------Madison
Mrs. L. F. Jermain ----------Milwaukee
Mrs. C. J. Boemer ----------Milwaukee
Mrs. Otho Fiedler ----------Sheboygan
Mrs. E. P. Crosby ----------Stevens Point
Miss Mary Elizabeth Crosby ----------Stevens Point
Miss Patsy Crosby ----------Stevens Point
Miss Misdinen Crosby ----------Stevens Point
Mrs. Orvil O'Neal ----------Ripon
Miss Mildred O'Neal ----------Ripon
Miss Marthaleen O'Neal ----------Ripon
Mrs. H. B. Nixon ----------Hartland
Mrs. Arthur Hazelton ----------Hartland
Mrs. E. F. Schneiders ----------Madison
Mrs. A. J. Wiesender ----------Berlin
Mrs. M. C. Borman ----------Milwaukee
Mrs. Ralph Waters ----------Madison
Mrs. E. G. Hastings ----------Madison
Miss E. Waters ----------Madison
Miss B. Waters ----------Madison
Mrs. F. A. Nause, Jr. ----------Sheboygan
Mrs. H. N. Winn ----------Madison
Mrs. F. E. Brinckerhoff ----------Beloit
Mrs. H. M. Carter ----------Madison
Mrs. James Dean ----------Madison
Mrs. Joseph Dean ----------Madison
Miss Cornelia Van Kooy ----------Madison
Miss R. M. Buellesbach ----------Madison

The Art and Practice of Medical Writing*

By MORRIS FISHBEIN, M. D.
Editor, Journal of the American Medical Association, Chicago

The Editorial Board of the Wisconsin Medical Journal considers itself particularly fortunate to be able to present this lecture as the fourth of a series published in consecutive months.

Since the last meeting I have made a trip to Montreal to attend an alumni meeting at McGill University. While there I visited the Osler library. Sir William Osler arranged at the time of his death for his library to be used for the furtherance of medical science. Dr. Francis, who is a nephew of Sir William Osler, is connected with the library. It contains the complete Thomas Browne collection, including every edition of the Religio Medici. There is also to be found the Osler collection of Rabelais. There is also a collection of the Osler manuscripts. I arranged to have a photostat made of one page from the last manuscript Sir William Osler wrote; from each one of his five copies of that manuscript. I am going to pass these five photostats around so you will have some conception of how Sir William Osler revised his manuscript.

Sir William Osler wrote the most popular text book on medicine. He had written for every important medical and lay periodical during the course of his lifetime. When he sent a manuscript in for publication he made five revisions of it before he was satisfied with what he had.

The first page consists of notes taken on small sheets of paper. Sir William Osler made such notes on small scraps of paper of various sizes and then assembled those notes by pasting the individual scraps, one after another, on long sheets of paper. This constituted the first draft of his manuscript. He then took this material and rewrote it by hand. His second draft consists of straightforward, hand written manuscript. He then apparently dictated from this written manuscript to a stenographer. His first typewritten draft is written in double space and contains innumerable corrections and revisions. Here are six or seven words struck out and shorter words put in.

Incidentally, in one paragraph he says, " . . . and among the nations as usual." He changes it to read, " . . . and as usual among the nations," putting the emphasis at an entirely different part of the sentence. I want to emphasize how he moved these two words to make a change in emphasis.

Then comes the manuscript given to the stenographer and which is again revised. He has prepared another draft, and after it is copied he crosses out an entire sentence, one that really should be eliminated. He asked himself a categorical question and then answered it; this is seldom good form in writing. It is much better to say what you have to say. When one interrupts one's flow of thought the audience's flow of thought is likewise interrupted.

Here he says, " . . . the nation's chief burden is to be borne," and he changes it to read, " . . . the nation's chief burden had fallen on that weary type." When you say, " . . . be borne by her," you think of an unwillingness in connection with the bearing of the burden, but when you say "fallen on," you understand that it was forced on the motherland.

Finally, in the fourth revision of the manuscript, which is the copy he sent to the editor, there is an absolutely clean page, with the exception of the editor's correction on that page. It seems that the editor found it necessary to cut out two quotation marks because the poem quoted was indented, and because it was obviously a copied poem and not a poem written by Sir William Osler. The editor found it necessary to make these two changes, but these are apparently the only changes the editor found necessary to make on that manuscript.

* Presented as one of a series of lectures offered under the joint auspices of the Medical Society of Milwaukee County and the Extension Division, University of Wisconsin, in Milwaukee, 1931.

ELIMINATION OF UNNECESSARY WORDS

Here is a new book. It is the second edition of an old book, entitled, "English and Science," published by D. Van Nostrand Company, Inc., 250 Fourth Avenue, New York, and written by Philip B. McDonald, Associate Professor in the College of Engineering, New York University. The author wrote this book primarily for mathematicians and scholars. He has much to say that would interest any writer in the field of medical science. His points cover the importance of writing lectures and the writing of technical papers. His reports are written in the third person. There is a chapter on style, correct language, obscurity, pomposity and ornateness of style. There is a most important chapter on conciseness, which he says is the cardinal secret of style.

I want to re-emphasize the use of correct English in the writings of essays, presidential addresses, or essays written for some special purpose. In such essays, if one is trying to be direct, it may be better merely to present what one has to say in as concise a manner as possible. I have read recently important addresses prepared for different bodies. I have been interested particularly in the brief way the thoughts of the authors were expressed. Dr. Henry Christian of Boston and Dr. Ray Lyman Wilbur are exceptional essayists. If you will read their recent addresses thoughtfully you will find they use short words, short sentences and speak directly; say what they have to say and get done.

This man, who is a Professor of English at New York University and who presents his views in this book, quotes the style of Herbert Hoover; the one style of Herbert Hoover, Engineer, and the other style of Herbert Hoover, President. This is an interesting contrast in literary style. A man who becomes a statesman finds it necessary to change his diction in addressing the multitude, apparently not to the advantage of either himself or the multitude.

IMPORTANCE OF PROPER WORDING

The writing of a resolution is a most important undertaking. I have sat in the House of Delegates of the American Medical Association and in the houses of delegates in at least twenty-four different State Medical Societies. I have heard men propound resolutions. It was fortunate that some of the resolutions were referred to a committee which had twenty-four hours to find out what the resolutions were about. Resolutions which define policies that affect the membership and go out to the public should be expressed in language which is absolutely clear.

McDonald quotes from James Harvey Robinson's book on "The Humanizing of Knowledge." That was an epoch making book. James Harvey Robinson not only popularized history but led the way in the endeavor to express science to the public in a manner which could be understood by the public. I doubt if there is any field in which this is more important, and one in which less competence is shown, than in the field of medicine.

Wingate M. Johnson, who has an article in The Atlantic Monthly for March, is not absolutely right in what he says, nor does he say anything distinctly new, but editors like his articles because he knows how to write. He has written articles for Harpers Monthly, for the New Republic, for the Nation and many other magazines. He is a country practitioner at Winston Salem. His writing is readable and makes an editor want to publish his material, and pay for it. There may be in the medical profession at least a hundred men who know more about the subjects he writes on than Wingate Johnson knows, but perhaps not another one who can express himself as well as Wingate Johnson expresses himself. Therefore what Wingate Johnson has to say reaches millions.

The Chicago Daily News publishes as one of its pamphlet series, a little book written by the Managing Editor, Henry Justin Smith, entitled, "It's the Way It's Written." That editor tells why it is that men who know what they want to say and can write what they want to say can have their ideas promulgated to the world, while perhaps ideas of equal importance are never expressed.

Nothing is so tiring to the average reader as to have the same phrase repeated frequently in a manuscript. I received a manuscript recently from a man who said, "It is a fact that:" "It is well known that:" "It is my experience:" "It is my own opinion." Of course it was his own opinion or he wouldn't be writing it. One can fall into the habit easily. Anyone who does much public speaking should have along a discerning friend to advise him. I found myself at one time using the word "thing" over and over. That word "thing" hit one person in the audience so obnoxiously he had to tell me about it. The repetition of the word "thing" dominated that person's perception. It reveals the importance of varying terms in order to hold the attention of the audience. When preparing a manuscript look particularly for the repetition of phrases: "It is important that:" "It is a fact that:" "Physicians have long debated the question that." In revising manuscript eliminate those phrases entirely or use different expressions.

PROFESSIONAL JARGON

Professional jargon refers to such words and phrases as: "acute abdomen." These must be avoided in writing papers for good medical periodicals, or even in conversation. In conversation conscious attempt should be made to avoid jargon, because only in avoiding it in conversation will you succeed in avoiding it when writing manuscripts. It is seldom necessary to add words to medical language. Most editors become greatly disturbed when they see them. I passed on a manuscript yesterday written by a fairly young man in New York. He has been four years in practice. He was writ-

ing on "The Pathology of the Appendix," and he found it necessary to use the words, "nephritis and nephrosis, appendicitis and appendicosis." That "appendicosis" was one reason why his manuscript was not accepted. In order to distinguish between two types of appendicitis he had to distinguish between appendicitis and an appendicosis. If I had an appendicosis or an appendicitis I would rather the physician didn't speculate around as to whether I had an appendicosis or an appendicitis. I would feel safer if he called it appendicitis and acted accordingly.

Then there is the patient who had a "chronic ear." There are the various terms used for influenza, which have been exceedingly frequent of late: fluenza, acute coryza, grippe, common cold, "catarrh."

I have mentioned the necessity of speaking scientifically. For instance, gonorrhea is not neisserian disease. Syphilis is syphilis and not "lues." Language changes in medicine but only with the advent of new knowledge. A doctor in Chicago, about five or six years ago, had a case of coma following carbon monoxide poisoning. He tried to explain that to a newspaper man the newspaper man discovered the term "petromortis." Newspapers seek new terms, and doctors unfortunately help them out.

STATISTICS

Few physicians have made a scientific study of "biometrics." Physicians are not taught in medical schools, as they should be, the proper evaluation of statistics. Some universities offer an elective course on this subject. If you looked over the manuscripts received by the Journal of the American Medical Association you would understand the need for the proper evaluation of statistics. One need not be a marvel at calculus; one need not learn the use of logarithms, but all should know how to evaluate scientific evidence.

In Raymond Pearl's "Medical Biometry and Statistics," there are some interesting points of practical value. He says, "If you toss two pennies up at the same time, what is the likelihood of their coming down heads or tails?" That is a point on which one could gamble. The biometrician knows that the speed with which they are tossed and the kind of a flip used will make no difference. The percentage will always be the same.

Raymond Pearl gives another example which is more important. He cites the question as to whether one wanted to make a bet that the next baby born will be white or black. He says that is a question that can be solved easily. After all there is a certain number of white residents and a certain number of black residents in the total population. Within the next five minutes, let us say, the next baby born in Milwaukee will be black. The actual fact of the matter is that there is no use in having the population figure. You would have to know whether the baby's mother was white or black. The question of the father might be a matter of even greater dispute. The question of the mother would be a determining factor. If you know that, you could make a reasonable bet.

It is seldom fair to send an editor a paper based on the questionnaire method. A competent or a trained biometrician might have difficulty in using the questionnaire. The average medical man is incompetent when it comes to using the questionnaire method in drawing conclusions.

A health officer in one of the eastern states wished some information having to do with the incidence of stillbirths in the population of that state: the causes of stillbirths and the methods of preventing stillbirths. One of the first things he did was to find out at what hour in the day most cases of stillbirths occur. He found that the vast majority of cases occurred between one o 'clock and seven o'clock A. M. He learned that far more cases occurred in the four to six hour period, between the hours of one o'clock and seven o'clock A. M., than at any other time. Then he wrote to the three leading obstetricians in the United States. He asked them why that was. In an amusing but not an enlightening manner they analyzed the situation. These three leading obstetricians all said the reason was that the obstetrician was so tired between one o'clock and seven o'clock in the morning that he was not able to give the cases the proper amount of attention. The natural reason would be that the mother was so tired at that hour, but that didn't occur to the three obstetricians. When analyzing figures scientifically, one must beware the personal point of view. (Here Dr. Fishbein discussed seven manuscripts.)

Question: What was the title of the book to which you referred?

The book is entitled, "English and Science," written by Philip B. McDonald and published by D. Van Nostrand Company, of New York. It is a well written book and full of interesting examples. The other book to which I referred was, "Medical Biometry and Statistics" by Raymond Pearl, published by W. B. Saunders Company of Philadelphia and London. I believe any doctor might well have a copy of this book.

In addition I would like to mention another book written by Raymond Pearl and published by the Knopf Company of New York, entitled, "To Begin With." It is a recommended bibliography of historical and scientific books, many written by masters of English composition. It is Raymond Pearl's conception of literature that every educated man, particularly in the field of science, should know. It is a fine essay on style in writing.

Question: Referring to case reports, I think you said one shouldn't say, "The patient entered the hospital."

I said that it is frequently unnecessary to say the patient entered. For instance, if the writer is associated with the hospital as a member of the staff, he may put an asterisk after the title and say, "From Milwaukee Hospital" as a footnote.

Addresses at the Dedication of the Beaumont Memorial; Prairie du Chien, Sunday, August Thirtieth

PRESENTATION OF LAND

By MRS. GOODSELL BILLINGS
Prairie du Chien

Dr. Harper, Visiting Members of the Wisconsin Medical Association, and Friends: As regent of the Fort Crawford Chapter of the Daughters of the American Revolution, I am very proud to present to the Wisconsin Medical Association the plot of ground on which has been erected this splendid memorial to Doctor William Beaumont. The local chapter of the Daughters of the American Revolution hopes, within a few years, to be able to restore a part of the military hospital which once occupied this site, and we feel that this tablet is a very fitting addition to this historic spot.

ACCEPTANCE OF LAND FROM D. A. R.

By C. A. HARPER, M. D.
President, State Medical Society of Wisconsin

Mrs. Billings, Ladies and Gentlemen: The State Medical Society of Wisconsin is deeply moved by the generosity of the Prairie du Chien chapter of the Daughters of the American Revolution. They, before us, saw the historical significance of this land. At a personal sacrifice they have insured its preservation.

They now present us with a portion that we may use it to perpetuate in granite and bronze the record of the work of one who contributed to its brilliant history. Without the splendid cooperation of the Daughters of the American Revolution we could not be here today and to its every member we extend our grateful appreciation.

Mrs. Billings,—we accept this plat, not as a gift but as a charge, and we hope that the Memorial we dedicate today may fulfill in some small part, your desires for the proper preservation of this richly historical spot.

POINTS OF PRAIRIE DU CHIEN HISTORY

By P. L. SCANLAN, M. D.
Prairie du Chien

The entrance of Joliet and Marquette into the Mississippi River at the mouth of the Wisconsin on June 17, 1673, marks the beginning of Prairie du Chien history. This place has always been an important entrepot for trade, and was the gateway into the great Northwest.

In 1682 the strategic importance of the place was realized by La Salle when he proposed an establishment here. In order to protect the fur trade, Nicholas Perrot in 1685 built a stockaded fort (Fort St. Nicholas) at the south end of our present-day Beaumont Road. In 1700 New France planned to build a fort at this point. The visit of Zebulon M. Pike in 1805 was for the purpose of selecting a site for a fort in this locality, and in 1810 when he first came as Indian agent, Nicholas Boilvin urged the necessity for a fort. In June, 1814, under the direction of General William Clark, a ravelin fort was erected on a large Indian mound about where the Dousman Villa now stands. It was captured by the British July 20, 1814, and the name of the fort changed from Shelby to McKay. The British held it until May 24, 1815, when they dismantled it, took the cannon and other valuables, and burned it.

After the War of 1812 it was here the United States decided to establish a military post. The troops under General Smythe came from St. Louis, selected the site of former forts and on July 3, 1816, under the direction of Colonel William S. Hamilton began the erection of a log fort—"Old Fort Crawford".

It was 340 feet square with bastions or towers on the northwest and southeast corners, the bastion on the southeast corner resting on an Indian mound. It housed the garrison and hospital. It was within this enclosure that Dr. Beaumont performed the experiments on the stomach of Alexis St. Martin.

General Zachary Taylor, later president of the United States, had orders in 1829 to make a new rock fort on the present site of St. Mary's Academy. The buildings were so far advanced by December 16, 1830, that the garrison was billeted within the walls. However, the sick and surgeon remained in the old fort and no account has been found of the time the sick quarters were changed to the new fort, or the time of the erection of this hospital whose ruins you now view. There is correspondence indicating that, because of a lien which Joseph Rolette held against the building, the government intended to give it up in 1835 as there was then enough room inside the fort itself for a suitable hospital.

Many pictures of the ruins are in existence, showing it in its different stages of disintegration. Beside the present ruins has been erected by the Wisconsin State Medical Society the Beaumont Memorial which we are dedicating today.

BEAUMONT, THE MAN

By WILLIAM SNOW MILLER, M. D.
Emeritus Professor of Anatomy
University of Wisconsin
Madison

Mr. Chairman, Members of the Wisconsin State Medical Society, Members of the Daughters of the Revolution, Dr. Antoine the Mayor, and Citizens of Prairie du Chien. One of the great names in the annals of American Medicine is William Beaumont, and we have met today to honor him, and his work, by the dedication of this memorial.

To the people in Prairie du Chien Beau-

(Continued on page 864)

PRESS SERVICE OF STATE MEDICAL SOCIETY

No serum does so much for public health as printer's ink

HIVES

Madison, Wis., Aug. 19—Hives, from which many people have been suffering this summer, is really not a disease but a symptom of an underlying cause which practically is a poison. This may be caused from eating certain acid fruits. It comes without warning to a person who is apparently well.

The Educational Committee of the Wisconsin Medical Society in a bulletin issued today recommends that the people bathe the afflicted parts with a solution of baking soda. Spirits of camphor may be used for hives caused by insect bites.

"At the present time physicians have certain tests applicable to the skin which may determine the nature of the foreign substance causing the trouble," declares the bulletin. "If there is any question about the cause, or if one does not obtain prompt relief from these simple domestic remedies, the family physician should be consulted.

"The causes of hives are many. It usually occurs from some foreign substance introduced into the circulation. The majority of cases come from food substances absorbed from the digestive tract, and which do not agree with the patient, or against which the system rebels because of a personal idiosyncrasy.

"Many persons, for example, are said to have a special susceptibility to hives upon taking a certain drug or some food-stuff like strawberries or shellfish. If one has repeated attacks of hives following eating one particular kind of food, the diagnosis is easy as to what caused the attack. Many times, however, the cause is not easy to discover, for there are individuals who react to such common foods as white of eggs, cakes, custards, etc. People, therefore, who are subject to frequent attacks should recall the food articles consumed prior to an attack in order that they may eventually determine the cause by exclusion.

"Sometimes external irritants produce hives, and it is occasionally due to specific disease conditions in the body."

* * *

THE EYES

Madison, Wis., Aug. 26—Before children are sent to school they should have their eyes examined. Many of the pupils in the grades who are looked upon as backward and dull by their teachers, are often suffering from some trouble of the eyes. Probably no single cause contributes more to backwardness among pupils in school than eye defects.

The Educational Committee of the Wisconsin Medical Society, in a bulletin today declares that grownups are able to detect defects of the eyes in themselves but often are found to neglect their children in this regard.

"A person has only one set of eyes to carry him through life," declares the bulletin issued today, "and when they are worn out a new set cannot be installed.

"Grownups, as a rule, know something of the care that should be given to their eyes, but children do not, and we can not start too early to safeguard these precious possessions for them.

"Babies, for instance, should sleep in a well ventilated but carefully darkened room. If they take their daytime naps out-of-doors, some arrangement should be devised for shading their eyes from the light. If the baby goes out in a carriage or go-cart for his daily airing, the hood should be tilted in such a way that his eyes at all times are comfortably shaded from direct sunlight. However, the exposure to light which is almost unavoidable when giving a baby a daily twenty minute sunbath does no harm.

"Equal care should be taken as the children grow older to see that their eyes are adequately protected. Children should always have as much sunshine and fresh air as possible, but a direct glare of light into the eyes should always be avoided. It is well to remember, too, in connection with any indoor arrangements that the eyes of children, like those of adults, are best protected when the light comes from the left side. Indoor play quarters should always be well lighted.

"Eye strain may develop very early in life, and children should be carefully watched for any signs of it. If they scowl or squint when they look at a toy or at their picture books, if they seem dull and listless, it is a wise plan to have them examined. Cross eyes should not be neglected but should be brought promptly to the attention of an eye specialist. One year of age is not too early to begin the treatment of cross eyes. The earlier the treatment is begun the better are the permanent results that may be expected, and if treatment is delayed one eye may become, for all practical purposes, permanently blind. Children's eyes should be examined as a matter of routine, before they are sent to school."

* * *

CANCER OF THE SKIN

Madison, Wis., Sept. 2.—Beauty has the advantage in a combat with some diseases. Women who care for their beauty seldom suffer with cancer of the skin. Each blemish is cared for when it comes and if it does not readily respond, medical attention is sought.

This is the conclusion reached by the Educational Committee of the State Medical Society of Wisconsin for the lower cancer rate of the skin among women as compared to men.

"Beautiful women and everyone who pays attention to the looks of the exposed part of the body observe at once the pigmented mole or the wart or the area of irritation of the skin, or the sore spot," declares the bulletin of the Medical Society issued today, "and when they seek an immediate examination and treatment they are protected from cancer. This information is pretty widespread among all groups of people today. Cancer on the bridge of the nose due to neglect of the irritation by the vanity glass has practically disappeared, because people, doctors, oculists and opticians now know the dangers, and, the moment an irritation appears, the type of frame is changed. The majority are beginning to learn that none should neglect any irritation of the skin anywhere.

"When the armies of the nations depended largely on their feet, the medical profession instructed the soldier on the protective care of the feet. It is more important today to teach the people about the proper care of the skin on any part of the body for protection against cancer than it was to instruct the soldier about his feet.

(Continued on page 862)

THE JOURNAL BOOK SHELF

Gould's Medical Dictionary. By George M. Gould, A. M., M. D . Edited by R. J. E. Scott, M. A., B. C. L., M. D. Third edition, revised and enlarged, based on recent medical literature; 1538 pages; with illustrations and one hundred and seventy-three tables, including three new tables of bacteria, metazoa, and protozoa pathogenic to man and animals by D. G. Bergey. P. Blakiston's Son and Company, Philadelphia, 1931. Flexible fabrikoid $7.00, indexed $7.50. Rigid fabrikoid, indexed $7.50.

Health on the Farm and in the Village. C. E. A. Winslow. Professor of Public Health, Yale School of Medicine. (Macmillan. 1931).

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1930. Cloth. Price, $1.00. Pp. 91. Chicago: American Medical Association, 1931.

Easier Motherhood. By Constance L. Todd. Price $2.00. John Day Company, Inc., 386 Fourth Ave., New York, N. Y.

New and Nonofficial Remedies, 1931, containing descriptions of the articles standing accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1931. Cloth. Price, postpaid, $1.50. Pp. 481 + LVI. Chicago: American Medical Association, 1931.

Proctoscopic Examination and the Treatment of Hemorrhoids and Anal Pruritus. By Louis A. Buie, B. A., M. D., F. A. C. S, section on proctology, the Mayo Clinic, Rochester, and associate professor of surgery, The Mayo Foundation, University of Minnesota. Octavo of 178 pages with 72 illustrations. Philadelphia and London: W. B. Saunders Company, 1931. Cloth $3.50 net.

Diagnostic Methods and Interpretations in Internal Medicine. By Samuel A. Loewenberg, M. D., F. A. C. P., associate professor of medicine, Jefferson Medical College; assistant physician to the Jefferson Hospital; visiting physician to The Philadelphia General Hospital, the Northern Liberties Hospital and the Eagleville Sanatorium for Consumptives. With 547 illustrations, some in colors. Second revised edition. Price $10.00 net. F. A. Davis, Company, Philadelphia. 1931.

A Clinical Study of Addison's Disease. By Leonard G. Rowntree, M. D., and Albert M. Snell, M. D., Division of Medicine, the Mayo Clinic and the Mayo Foundation, Rochester, Minnesota. 12 mo. of 317 pages with 41 illustrations. Philadelphia and London: W. B. Saunders Company, 1931. Cloth, $4.00 net.

BOOKS RECEIVED FOR REVIEW

Gonorrhea In The Male And Female. By Percy S. Pelouze, M. D., associate in urology and assistant genito-urinary surgeon at the University of Pennsylvania; fellow of the Philadelphia College of Physicians, Philadelphia. Second edition, revised. 440 pages with 92 illustrations. W. B. Saunders Company, Philadelphia and London. Cloth $5.50 net. 1931.

The Practice of Medicine. By A. A. Stevens, A. M., M. D., professor of applied therapeutics in the University of Pennsylvania; visiting physician to Philadelphia General and University Hospitals; consulting physician to St. Agnes' Hospital, Philadelphia. Third edition, entirely reset. 1150 pages, illustrated. Philadelphia and London, W. B. Saunders Company, 1931. Cloth $8.00 net.

Clinical Laboratory Methods. By Clyde L. Cummer, Ph. B., M. D., F. A. C. P., formerly associate clinical professor of clinical pathology, School of Medicine, Western Reserve University, Cleveland; instructor in dermatology and syphilology, School of Medicine, Western Reserve University; visiting dermatologist, Charity and St Alexis Hospitals, Cleveland. Third edition, thoroughly revised. Illustrated. Price $6.75 net. Lea & Febiger, Philadelphia, 1931.

Simple Lessons in Human Anatomy. By C. H. Harvey, M. D., professor of anatomy, University of Chicago. Illustrated. American Medical Association, Chicago.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, 424 N. Charter Street, Madison, Wis.

Bedside Interpretation of Laboratory Findings. By Michael G. Wohl, M. D. Associate Professor of experimental medicine, Temple University Medical School; chief of Metabolic Clinic, Temple University Hospital and chief of the First Medical Diagnostic Clinic, Mt. Sinai Hospital, Philadelphia, Pa. Illustrated. Price $6.00. C. V. Mosby Company, St. Louis, Mo. 1931.

This is another clinical laboratory guide under a new name, Bedside Interpretation of Laboratory Findings. The title suggests a discussion of the fundamental importance of the correlation of symptomatology, physical signs and the results of functional and pathological studies. One is disappointed to find that it is a primer of laboratory methods embelished by the enumeration of a few of the limitations of laboratory procedures as applied to clinical diagnosis.

Clinical bacteriology has been almost completely left out. There is a brief discussion of some of the bacteriological findings in the examination of sputum. In the discussion of the presence of pneumococci in sputum, the impression is left that the recognition of these organisms can be accomplished by a simple staining method and microscopic examination, although typing tests are said to be advisable.

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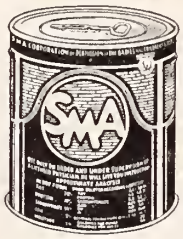

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There is a chapter on laboratory tests for pregnancy in which the tests are briefly described with but meager discussion. W. D. S.

Medical Jurisprudence. By Carl Scheffel, Ph. B., M. D., LL. B. Price $2.50 net. P. Blakiston's Son & Co., Inc., 1012 Walnut St., Philadelphia, Pennsylvania.

In this volume the subject is presented from the legal aspect rather than the medical aspect. In other words it gives us concrete illustrations of how the physician is affected by the law rather than how medical matters may affect or influence the solution of various legal problems. In doing this, the presentation is made in seven chapters, six of which pertain to the law of contracts, agency, torts, evidence, property and criminal responsibility.

In the chapter on the contractual relations of physicians it is pointed out that the law does not consider that the practice of medicine and surgery is any more idealistic than any other business and, in addition to being subject to the laws which govern business in general, is subject to certain additional laws which have been formulated for the protection of society. In this chapter and in the chapter on Agency, the author has discussed contracts for personal services, the physician's obligations to render services, his right to collect fees, contracts involving property, the status of physicians' assistants and many other topics. In the chapter on torts are many valuable suggestions regarding negligence and torts of others for which the physician may be liable. The chapter on evidence likewise takes up pertinent questions regarding testimony, and the rights and duties of physicians as witnesses. It shows how wide the gap is between the legal conception of this subject and the medical man's idea as to what it should be.

Chapter 5 defines and interprets the legal meaning of the word property insofar as the physician is concerned, and chapter 6 briefly notes some of the legal views regarding the criminal negligence and criminal responsibility of the physician.

In chapter 7 the author boldly points out several facts which, if well taken, should have some wholesome effect upon those whose duty it is to suggest medical legislation. The whole tone of the chapter implies, at least, that if the medical profession as a whole had a knowledge of the fundamental, basic principles which underlie many of the decisions enumerated, it would be better able to diagnose and treat its own legal ills, real and imaginary.

R. L. McI.

Cutaneous X-Ray and Radium Therapy. By Henry H. Hazen, A. M., M. D. Professor of dermatology, Medical Department of Georgetown University; professor of dermatology, Medical Department of Howard University; Member of American Dermatological Association, American Roentgen Ray Society. Illustrated. Price $3.00. C. V. Mosby Co., St. Louis, Mo. 1931.

In the preparation of this small work of 156 pages, the author has attempted to outline some of the points that "will aid in the selection of cases for irradiation, give safe advice as to the technic and warn against the many pitfalls" which lie in the pathway of the physician who uses radium and x-rays.

In the first chapter, which deals with the physics of Roentgen rays and radium, there are definitions of the several rays and statements as to their characteristics. Chapters two and three discuss x-ray and radium apparatus, their standardization and dosage estimation. While most of the statements made here are pertinent, it seems somewhat inconsistent to say that while "no two x-ray outfits of the same type will deliver precisely the same dosage . . . and for this reason should be thoroughly standardized" and then to intimate that the biological method of testing is the only really safe way by which this standardization may be accomplished. It may be that the author fell into error in stating that "up to the present time no ionization machine has stood the test of time" and it may be as well to point out the fact that the International Congress of Roentgenologists does not feel that the biologic test is superior to the physical. This is mentioned for two reasons. In the first place, it may be that the physical calibration is more accurate and more reliable, and if it is, the physician and his patient both are entitled to this knowledge. Secondly, because of the fact that in the near future it is believed that the physician who has had his x-ray machine calibrated in international or (Roentgen unit) will be standing on better ground from a legal point of view than will the physician who has depended entirely on the biologic tests. Furthermore, the calibrated outfit can be tested biologically so that both tests may be employed.

The last twelve chapters of the book discuss the treatment of the several groups of cutaneous diseases in a brief, orderly manner giving usually a brief definition of the disease and suggestions as to the amount of irradiation to be used in the treatment. The author intentionally omitted all but a few photographs and those given are not particularly helpful. There is no point in putting a photograph of an adult hand which shows a dermatitis due to soap, in the middle of the paragraph on infantile eczema.

The main objective of the book is apparently to point out the many details of technic and procedure which the operator must observe and which, if not followed, may lead to untoward results. These are all well taken and cannot be repeated too often.

R. L. McI.

Modern Proctology. By Marion C. Pruitt, M. D., L. R. C. P., S. (Ed.), F. R. C. S. (Ed.), F. A. C. S., Atlanta, Ga. Associate in surgery, Emory University School of Medicine; assistant visiting surgeon, Grady Hospital; Proctologist, Crawford W. Long Memorial Hospital, and Clinic, Georgia Baptist Hos-

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pital, and Anti-Tuberculosis Association. With 233 illustrations. Price $8.00. C. V. Mosby Company, St. Louis, Mo. 1931.

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PRESS SERVICE

(Continued from page 857)

"Seventy years ago the most common form of cancer of the skin was among chimney-sweeps due to their occupation and their ignorance of cleanliness. This form of cancer of the skin has disappeared, because the occupation has disappeared. There is evidence that all forms of cancer of the skin will disappear when the people and the medical profession learn and practice the care of the skin just as cancer of the mouth will disappear when people learn and practice the care of the mouth and teeth."

* * *

THE CHILDREN'S MEALS

Madison, Wis., Sept. 9—Children eat more because they play more. A man working in a forest may require twice as much nourishment as a banker. A child that is playing vigorously all day needs as much food as an adult.

In a statement entitled "Fill Up the School Dinner Pail", the Educational Committee of the State Medical Society declares that at times the appetites of children seem insatiable, and that many times a twelve year old boy eats twice as much as his father, who has double his weight. The growing child, according to the bulletin, should be given plenty of food.

"Every muscular motion results in the giving off of heat," declares the bulletin issued today; "consequently after severe exercise one is hot and perspires, and the face is flushed. The Canadian lumberjack, tramping through the snow in the cold, piercing winds, chopping and sawing large trees, gives off six or more times the amount of heat given off by the equally heavy but sedentary banker in his well-warmed office, to which he journeys in his limousine.

"As children are normally very active, they give off a great deal of heat, and as the heat must be produced either from food or from body substance, they must, in order not to lose weight, eat a great deal. Full activity, high spirits, active vital processes are a child's best inheritance. The play instinct is natural in the child. Food economy has no place in his life. A rosy, chubby, active baby and a well built, sturdy boy are normal. The emaciated, listless child is not normal. The latter needs and burns up less food than the former. Many children have only one good meal a day; they cannot be an active and romping set; the meager food they get just suffices to sustain them in listlessness and depression, in no sense a normal life for children. While the gasoline power saw and lumber tractor may replace the work and thus some of the food needed by the lumberman, and the banker may frequently well afford to live on less food, no substitute can be offered to meet the needs of the active, growing, healthy child. Exercise is needed for proper development of frame and muscles, heat and lungs. This exercise calls for heat, and heat comes from fuel, which is food, and thus we have in part an explanation of the tremendous appetite of the child.

"In addition to the food needs for the intense juvenile activity, there is the important factor of growth, for the growing child absolutely must have an extra supply of food from which, by the processes of digestion, material may be absorbed, and then in the elaborate body machine again reconstructed into body flesh, fat and bone.

"Two demands for food, muscular activity and growth, are more or less obvious, but recent studies of children have shown a third, less easily observed, special demand for larger food intake, that is, the specific high internal vital activities of the quiet, resting child. Even in quiet sleep there is internal muscular activity, such as that of respiration and heart action, so that heat is being produced and given off incessantly, though, of course, in much less degree than during exercise."

* * *

DISEASES OF THE HEART

Madison, Wis., Sept. 16.—Diseases of the heart are preventable in the majority of instances except in congenital cases and in extreme old age, yet it has become one of the most menacing causes of death in all countries, and the rate is rapidly rising in Wisconsin. In twenty years the Wisconsin rate has nearly doubled.

The State Medical Society attributes this increase to larger number of people reaching old age limits, to the over-stimulated activity of the age, and to diseases unattended to during youth. The death score for Wisconsin from heart disease for the past six years is as follows:

1925	4368
1926	4740
1927	5167
1928	5736
1929	6200
1930	6081

The Wisconsin State Medical Society in a bulletin issued today declares that few people have unhealthy hearts in the beginning and that most heart diseases have been caused by rheumatism, tonsillitis, St. Vitus' dance, decayed teeth and some of the infectious diseases, especially scarlet fever.

"When the infecting agent is carried, it plants itself on the curtains of the valves, on the structures about the valves and in the heart muscle," declares the bulletin. "It causes an inflammation, and, when the inflammation has subsided, it leaves in its wake scarred and distorted tissues that interfere with the proper working of the delicate mechanism of the valves.

"The time to remove diseased tonsils is before they have an opportunity of infecting the heart. Only complete removal will be satisfactory, since a few remaining crypts may contain enough infective bacteria to menace the heart. All tonsils need not be removed, but only those which most physicians, and many of the laity of today, clearly recognize as diseased and potentially dangerous. Diseased tonsils are a great source of rheumatism, a great source of danger to the heart, and when they are removed the danger often goes with them and the general health is improved.

"The teeth should be carefully inspected at intervals of six months, and any doubtful ones should be x-rayed by an expert. Good teeth help toward perfect digestion, and this in turn aids the general health and raises the bodily resistance to disease. All other areas of local infection should be sought out by the physician and removed. Cleaner mouths, earlier recognition and prompt treatment of sore throats and greater protection against the so-called infectious diseases of childhood, such as scarlet fever and diphtheria, will reduce the number of cases of heart disease."

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BEAUMONT, THE MAN

(Continued from page 856)

mont is no stranger, and they know many of the events in his life; but to the great majority he is unknown. I shall, therefore, give a resumé of the principal events in his life, leaving the account of his work as a physiologist to my colleague, Prof. W. J. Meek.

William Beaumont was born at Lebanon, Connecticut, November 21, 1785. In the winter of 1806–07, at the age of twenty-one, he left home with "a horse and cutter, a barrel of cider, and $100.00 of hard earned money." We do not know the circumstances which made him make this move. After passing through western Massachusetts and Vermont, he reached early in 1807, the village of Champlain, New York. Here he taught school, tended store, and began the study of medicine. One of his pupils was James H. Lockwood, who again entered into his life at Prairie du Chien.

In 1810, Beaumont apprenticed himself to Dr. Benjamin Chandler, of St. Albans, Vermont, and for two years followed him in his daily rounds making careful notes of each case. At the end of this time Beaumont was licensed to practice medicine by the Third Medical Society of the State of Vermont.

On the declaration of war with England in June, 1812, Beaumont crossed Lake Champlain to Plattsburgh, New York, presented his credentials to the proper authorities, and on September 13, was brevetted surgeon's mate in the Sixth Regiment Infantry. For a short time he was transferred to the Sixteenth Infantry; but in February, 1813, he was transferred to his original assignment.

In March, he marched with his brigade from Plattsburgh to Sackett's Harbor, a distance of 180 miles, and on April 24, he sailed for Little York (Toronto) and took part in its capture. Here he had plenty of surgery; for the British blew up the magazine connected with the fort, and as his regiment was the most advanced it suffered severely; 20 being killed and 109 wounded. Through the night of April 27, and the following day, he was busy doing all kinds of operations and dressing wounds.

OTHER CONTRIBUTORS

Additional contributors to Beaumont fund whose contributions were too late to include in the September Journal are:

Dillman, A. E. ----------Steuben
Sisk, Ira R. ----------Madison

On May 8, he left Little York for Niagara and was present at the battle and capture of Fort George and the adjoining village of Newark. The wounded from the battle of Little York and Fort George were eventually removed from Newark to Lewiston, New York, on the opposite side of the river, because of much sickness among the soldiers, due to the low, marshy ground. Beaumont served in the hospital at Lewiston until he contracted the prevailing epidemic. How long he was ill we do not know; but Surgeon Mann states that during the month of August more than one-third of the soldiers were on the sick list and "of seven surgeon's mates, one died, three were on leave of absence by reason of indisposition, and the other three were for a short time ill."

On September 11, 1814, Beaumont took part in the battle of Plattsburgh and was commended by Surgeon James Tilton for his coolness and bravery under fire.

After the conclusion of peace between England and the United States, President Madison reduced the army, and a proportionate number of officers were dismissed. Only those having the most merit were retained; among this number was Beaumont although others higher in rank were dropped from the service. Beaumont, however, was dissatisfied with the conditions in the service and resigned late in 1815. He then began private practice in Plattsburgh, and at the same time opened a combined grocery and drug store.

In 1818, Dr. Joseph Lovell was appointed Surgeon General and at once reorganized the service. Beaumont applied for readmission, and was commissioned post surgeon by President Monroe. He was immediately ordered to report for duty at Fort Mackinac, which he reached on June 16, 1818, and two days later assumed charge of the hospital.

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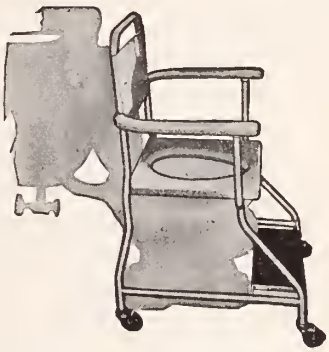

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At the time Beaumont reentered the army he was engaged to Deborah (Green) Platt of Plattsburgh. In March, 1821, he applied for a furlough. This was granted and he went to Plattsburgh where he was married on August 28, 1821, returning to Mackinac with his bride.

On June 6, 1822, one of the employes of the American Fur Company, Alexis St. Martin, accidentally received a gun shot wound in his side which, through the skillful attendance of Beaumont, eventually healed, leaving a permanent opening into his stomach. Beaumont finally recognized that here was an opportunity to study the process of digestion; but he did no serious work on the subject at Mackinac.

In May, 1825, Beaumont was ordered from Fort Mackinac to Fort Niagara and took St. Martin with him. From Fort Niagara Beaumont published his first series of experiments—four in number. In July he was granted a short furlough and left Fort Niagara for Plattsburgh, taking St. Martin with him. The proximity of his old home in Canada caused St. Martin to take "French leave" and it was some years before he again entered Beaumont's service.

In May, 1826, Beaumont was ordered to Fort Howard, Green Bay. While there he witnessed the spectacular surrender of Red Bird. He was the first physician to introduce vaccination, in order to check the epidemic of small-pox in the Fox River Valley, during the winter of 1827–28.

In 1828, Beaumont was ordered from Fort Howard, where he spent two enjoyable years, to Fort Crawford, Prairie du Chien, where he arrived August 10. Atwater describes some of the hardships with which the officers and their families had to contend at Fort Crawford as follows:

"Lieut. Col. Z. Taylor, has been in the Indian country constantly with his family about twenty years. Here he and his lady, who were bred in the most polished and refined society, have been compelled to rear as well as they could a worthy and most interesting family of children. Col. Taylor commands Fort Crawford at Prairie du Chien. Dr. Beaumont and his amiable and accomplished lady; Major Garfield and his, belonging to this Garrison, are doing the same. It is an interesting sight, to see such persons located as they are, in a fort, on the very verge of civilized life, educating a family of young children."

The officers maintained a library at their own expense, which contained not only general literature, but also works which were connected with their various professions.

St. Martin left Beaumont in September, 1825, and remained in Canada four years. Through the agency of the American Fur Company his whereabouts were discovered in 1827; but it required two more years before he could be induced "after considerable difficulty, and at great expense" to again enter the employment of Beaumont. In August, 1829, having been transported nearly two thousand miles, St. Martin reached Prairie du Chien.

Here he remained until March, 1831, and during the interval Beaumont performed many experiments, of which he recorded fifty-six. *It was not* at Mackinac, though it was there that the opportunity and inspiration came to him; *it was not* at Fort Niagara, from which he published four experiments; *it was here* in Prairie du Chien that he did his fundamental work, and all of his future work was based upon what he accomplished here. *This fact should be kept in mind, with pride, by every citizen of Prairie du Chien and Wisconsin.*

Time will not permit me to tell of all the interesting events during Beaumont's service at Old Fort Crawford. He missed the great Council of 1825; but he was present at that of 1829, when thousands of Indians assembled on the plain in front of Old Fort Crawford. He witnessed the frantic orgy of the Sioux and Menominees following the massacre of the Sauk and Foxes. He went out with his regiment, and served in the Black Hawk war, and after his return cared for the soldiers suffering from cholera, which had been brought to Prairie du Chien by Eastern troops. He made a careful study of the Intermittent Fever which prevailed in Prairie du Chien, correlating the epidemic with the stagnant pools of water and the marshes, but had no idea of its

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed care Wisconsin Medical Journal.

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origin. It was not until 1880 that the true cause was discovered by Laveran.

The Black Hawk war interfered seriously with Beaumont's plans. He had applied for a furlough of a year that he might take St. Martin to Paris and receive that assistance from the physiological chemists of which he felt the need. On July 13, 1831, a special order was issued granting his request; but on October 24, it was recalled on account of the impending Black Hawk war. After the close of the Black Hawk war a special order was issued granting him six months furlough. He accordingly left Prairie du Chien for St. Louis, and from St. Louis went directly to Plattsburgh, New York, where he met St. Martin, who had returned from Canada. From Plattsburgh, Beaumont went to Washington and finally decided to spend his furlough there and continue his experiments with St. Martin.

From Washington, Beaumont wrote Thomas P. Burnett, Sub-Indian Agent at Prairie du Chien: "It is with peculiar pleasure and satisfaction that I reflect upon the scenes of social enjoyment, incident to our residence at Prairie du Chien." He then goes on and compares the "hollow-hearted, affectedness" of Washington society with that of Prairie du Chien.

From Washington, Beaumont was ordered to New York, and then to Plattsburgh where he continued his experiments and began the preparation of his book in which he describes all of his experiments. This was published at Plattsburgh in 1833.

St. Martin left Beaumont at Plattsburgh and went to Canada, promising to return. Beaumont waited some time in Plattsburgh for St. Martin; but "although strenuous efforts and attractive offers were made, Alexis could not be induced to again enter the service of Beaumont."

Beaumont was ordered from Plattsburgh to Jefferson Barracks, St. Louis. Here he found that all was not harmonious, and expressed a desire to be transferred to Prairie du Chien. Possibly he did so because of the friendships he had formed there, and because of the "new" Fort Crawford in which he knew he would have pleasant quarters.

In due time the order for his transference came, and he went to Washington and Plattsburgh on a three months' furlough. On his way north he stopped at Washington and had a conference with the Surgeon-General and, possibly because it was intimated to him that Fort Crawford was eventually to be abandoned, he decided to remain in St. Louis.

Surgeon General Lovell died in October, 1836, and Beaumont lost his best friend; one who appreciated his work and had given him every opportunity to carry it out. Thomas Lawson succeeded Lovell as Surgeon General, and from that time Beaumont was subjected to many evidences of his animosity. There seems no doubt that Lawson was jealous of the reputation Beaumont had acquired; his attitude finally led Beaumont to resign from the army in 1839 and take up private practice in St. Louis, where he quickly built up a lucrative business.

In March, 1853, on his way home from the bedside of a patient, late in the evening, he slipped on some ice-covered steps, striking his head violently. He recognized the seriousness of his injury and prophesied its termination. He died on April 25, 1853, and was buried in that beautiful cemetery at St. Louis, Bellfontaine.

In conclusion I can do no better than to quote Osler's estimate of Beaumont. "His work remains a model of patient, persevering investigation, experiment, and research, and the highest praise we can give him is to say that he lived up to and fulfilled the ideals with which he set out."

DR. WILLIAM BEAUMONT, THE PHYSIOLOGIST

By WALTER J. MEEK, M. D.
Professor of Physiology, University of Wisconsin

This tablet says that Dr. Beaumont was a pioneer in Physiology, and although the inscription is far more intelligible than most inscriptions are, many will pass this way who will wonder just what a Physiologist is anyway and what this particular one did to justify this memorial.

A physiologist is one who experiments

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with living things. He is one who loves nature but is not satisfied with the mere shapes and names of our bodily parts. He sets before himself the task not to answer "Why" but "How do we move and live and have our being?". He is a student of action, of all the obvious as well as the hidden responses that we make in adjusting ourselves to the things around us.

Such a man was Dr. Beaumont. But physiologists are not so rare that each one deserves his name engraved in bronze. About this man there must have been characteristics that marked him off from the mine run of his profession. The qualities of greatness are much the same in all the walks of life. Ability, insight and intense devotion to the work in hand always raise a man above his fellows. It was because this physiologist possessed these qualities in a marked degree that we have met here today.

The word "Pioneer" is most aptly chosen. One might have been tempted to say "Our first American Physiologist", but that honor goes to a young student of Pennsylvania. Dr. Beaumont was however an early explorer in one of the most important fields of physiology, just as he was a member of that band of pioneer soldiers, miners and farmers who opened up the great Northwest.

He had ability of an unusual degree as well as that intuitive power without which the man of science is well nigh helpless. Long before the time of Alexis St. Martin men had been unfortunate enough to have had accidental punctures into their stomachs, and these cases had even been reported by the medical profession. Beaumont alone saw the opportunity offered for physiological investigation. Others saw an interesting pathological case. Beaumont saw an answer to the question "How does the stomach digest food?".

The devotion of this poorly paid army surgeon to his scientific opportunity is one of the most inspiring chapters in all the history of American science. With literally nothing but a thermometer and a sand bath, a thousand miles away from the nearest chemical laboratory, he propounded fundamental questions on digestion and planned clean cut experiments to answer them. Nothing could stand in the way of his enthusiasm. Today with thousands of dollars at our disposal and palatial laboratories in which to work, we are put to shame by his example. Brains and the willingness to sacrifice are at a premium as they always were, and both were possessed by our "Pioneer Physiologist".

In forming an opinion of a man's real value as a physiologist one must remember the scientific condition of his times. One hundred years ago when Dr. Beaumont was working at old Fort Crawford there was no such a science as organized physiology. Ludwig, Helmholtz and Bernard, the great masters of this medical field were boys of five, ten and eighteen years. Hoppe-Seiler was five years old and Kühne and Emil Fischer were yet unborn. Beaumont never heard such terms as "protein", "enzyme", "calories" or "vitamines". To us who are deluged with publications it is amusing to hear Beaumont say that his "age is prolific of works on physiology", and for that reason he must assign sufficient motives for offering the public still another book on the subject. The remarkable thing is that he had apparently read the few foreign books that did deal with the problems of digestion, for his references to them are full and accurate. Where he found these precious volumes we should like very much to know. At any rate from his readings and studies he outlined in a clear direct fashion the whole field of gastric digestion. When a truly great man approaches his problem he is full of preconceived ideas but he has no preconceived opinions. Beaumont's own outline of his book shows that he had planned his lines of investigation in an orderly logical manner.

1. Of Aliment.
2. Of Hunger and Thirst.
3. Of Satisfaction and Satiety.
4. Of Mastication, Insalivation and Swallowing.
5. Of Digestion by the Gastric Juice.
6. Of the Appearance and Motions of the Stomach.
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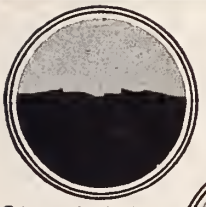

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These are the very topics we are interested in today. One hundred years ago this versatile man paragraphed a modern textbook.

Not only did Beaumont know his field, as we should say today, but he showed prophetic shrewdness in his deductions. He found that finely divided foods, both animal and vegetable, digested most readily and that blood had to be digested the same as meat. These were not isolated facts to him, for he related them and concluded that the "Ultimate principles of nutriment are probably always the same whether obtained from animal or vegetable diet." It was not until the time of Emil Fischer in the present century that we even understood these words of Beaumont, but now we know that he was thinking clearly and correctly far ahead of his time.

No one contributed more than Beaumont to what we may call the practical science of dietetics. He was interested in the time it took Alexis to digest his foods, and the tables he prepared showing the lengths of time various substances remain in the stomach are still valuable. They speak a great deal for the zeal of Dr. Beaumont and for the patience of Alexis.

The work of Beaumont appeared in time to settle one of the famous controversies of his time, namely whether the stomach and gastric juice existed to dissolve the food or whether the stomach was an organ for grinding and fermentation. Beaumont found that pure gastric juice kept in a bottle as long as a year still had the power to put meat and vegetables into solution. He concluded therefore correctly that the juice was a solvent. He also recognized the acidity of the gastric juice as Prout had done and sent some of it to Professor Silliman at Yale who found that there was free hydrochloric present. Beaumont thus helped settle the old controversy as to whether the acid was acetic, phosphoric or lactic. It was none of these, but hydrochloric.

To continue mentioning the remarkable things this physiologist accomplished here in the northwest wilderness would inflict you with a physiological lecture. I have mentioned a few however to emphasize the point that his work has lasting value. He is still our contemporary.

We have met here then to honor the memory of our colleague, not because he wrote a book at the time when scientific books in America were non-existent; not because he was a Physiologist at a time when such characters were practically unknown in these United States; but because he was a truly *pioneer* Physiologist, one who charted an unknown field and blazed the way for scientific highways that we still follow with profit and satisfaction.

DEDICATION OF THE BEAUMONT MEMORIAL

By DR. C. A. HARPER, M. D.
President, State Medical Society of Wisconsin

It is given to few to have made such an epochal achievement that it lives in the minds of men a hundred years later. The pioneer work of Doctor William Beaumont was such an accomplishment. He was a pioneer, not for fame, not for wealth but for knowledge. Under hardships unknown to our present generation, he did his great work on this soil,—won here his great laurels.

We, his professional brethern of another generation, place and dedicate the Memorial here today, not alone to honor the man. We vision the spirit of a great physician who would rather delight in doing a piece of scientific investigation that might prolong the lives of fellow men, even for but one more useful and happy day, than to accumulate riches.

As we gather here today, we cannot but be conscious of the fact that while some are in fortunate circumstances, many face a winter of want and privation. We have conquered many of the diseases of man but others remain for our future conquest. We have conquered great economic problems but others as great remain to challenge us. So it is our fervent desire that this granite boulder with its plaque of bronze shall honor the man by inspiring others to follow

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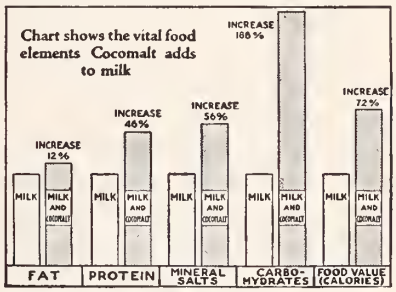

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his ways. The opportunity to be great physicians is given to us all. Some will pursue that ambition in medicine and, by faithful service to the community in which they live, each will find his memorial engraved on the hearts of his fellow men. Others may be great physicians in the field of law, economics, banking, education, farming, the ministry or journalism.

But in whatever walk of life, always the great physician, like William Beaumont, will be he who strives to benefit the race. Though he may never seemingly achieve the results of a Beaumont, if he works that his and future generations may benefit,—then surely he is a great physician. Perhaps it may seem to you that it is given to men of medicine, somewhat more frequently than to others, to work for the common good. But let me assure you that it is a privilege that is not confined to the medical profession and as this is true so is it our hope that in honoring a great pioneer, the granite and bronze will tell a story to those who pause and read that may inspire others to be great physicians.

To William Beaumont, Doctor of Medicine, Pioneer Physiologist, I dedicate this memorial erected by the members of the State Medical Society of Wisconsin, to honor that spirit of conquest for humanity's sake that wins the only undying fame,—that earns the gratitude of every understanding heart.

Acceptance for the City of Prairie du Chien

By F. J. ANTOINE, M. D.
Mayor, City of Prairie du Chien

Dr. Harper, Daughters of the American Revolution, Ladies and Gentlemen: In accepting this marker of granite and bronze this afternoon, I wish to express gratitude in the name of the city of Prairie du Chien and vicinity to the State Medical Society of Wisconsin for conceiving and executing plans for this wonderful occasion. I wish particularly to congratulate two members who are outstanding on this occasion: Dr. Scanlan for his research as an historian, and that most lovable character and historian who thinks more of Prairie du Chien than any citizen, the man who is the father of this monument—Dr. William Snow Miller.

It is perfectly true that we who live here and live in the shadows of these events realize, in part, the significance of this occasion. In accepting this monument, citizens and members of the State Medical Society, we do so with full understanding of its responsibility. It is not a monument for the city of Prairie du Chien alone. However, this city is in a fortunate position, for the work of Beaumont was done here. We have here a monument of granite and bronze,—a marker that will go down through the ages. Coming generations will view this monument and read of this dedication at Prairie du Chien—August 30, 1931. I know, Mr. President, that I am not wrong when I say we are to be congratulated upon being the recipients of this monument.

Durable as it is, and as long as it will live, this monument will not live a moment longer than the fame of this man whom we are honoring. This man's name is known in French history as well as in Hindu, German and Japanese literature and in that of many other countries. He does not only belong to Prairie du Chien or to the State of Wisconsin alone. He does not belong to the United States alone. He is a world figure. With this thought I am honored in accepting this monument for the city of Prairie du Chien. The city of Prairie du Chien also has something to offer, for the street which this Memorial faces, from the southern city limits to the northern city limits of the city, has been given the name of Beaumont Road.

UNVEILING OF MEMORIAL

To unveil the Memorial we are honored with the presence of a little girl of 7,—Mary Adell Keating. She is a direct descendant of Oliver Cherrier, who as one of the earlier pioneers in Wisconsin, settled in this city in 1792, when it was not a city but a fort of the old frontier and I am gratified to be able to present to you now Miss Mary Adell Keating, who will conclude this dedication by unveiling the Beaumont Memorial.

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(Six Servings)

	Grams	Prot.	Fat	CHO.	Cal.
1½ tablespoonfuls Knox Sparkling Gelatine	10	9	..	..	..
¼ cup cold water	..	..	..	..	..
1 square chocolate, grated	30	4	15	9	..
¾ cup hot water	..	..	..	..	..
¾ cup milk	180	5	7	9	..
2 eggs	100	13	10.5	..	..
¼ cup cream, whipped	60	2	18	2	..
5 tablespoonfuls sugar	40	..	..	40	..
1 teaspoonful vanilla	..	..	..	..	..
Few grains salt	..	..	..	..	..
Total		33	50.5	60	826.5

Soak gelatine in cold water. Heat chocolate, water, milk and salt over hot water, then add gelatine and stir until dissolved. Separate eggs and beat egg yolks until lemon colored. Stir hot mixture slowly into egg yolks. Return to stove and heat over hot water until mixture thickens slightly. Remove from stove, add vanilla and chill until nearly set. Beat egg whites until stiff, fold into jelly, also whipped cream. Mold and chill until firm.

LEMON MIST

(Six Servings)

	Grams	Prot.	Fat	CHO.	Cal.
1 tablespoonful Knox Sparkling Gelatine	7	6	..	..	..
¼ cup cold water	..	..	..	..	..
1½ cups hot water	..	..	..	..	..
Grated rind 1 lemon	..	..	..	..	..
¼ cup lemon juice	40	..	..	4	..
2 eggs	100	13	10.5	..	..
2 tablespoonfuls sugar	16	..	..	16	..
Total		19	10.5	20	250.5

Soak gelatine in cold water. Boil rind of lemon in water used for dissolving gelatine; add sugar; pour on soaked gelatine—stir until dissolved. Pour this into well beaten egg yolks. Return to stove and cook over hot water until mixture thickens slightly, stirring constantly—add lemon juice and pinch of salt. When nearly set fold into egg whites which have been beaten stiff. Mold and chill.

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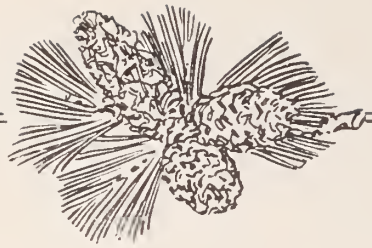

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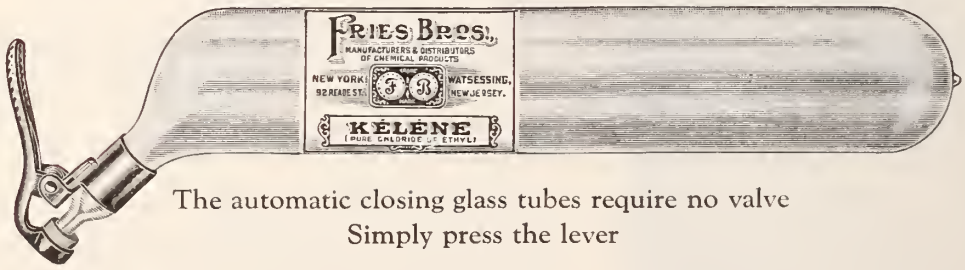

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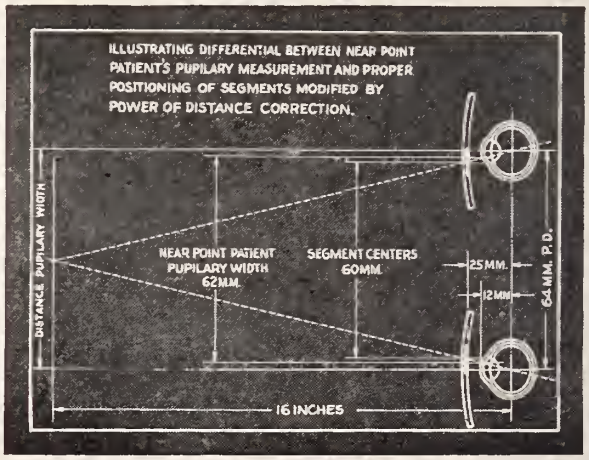

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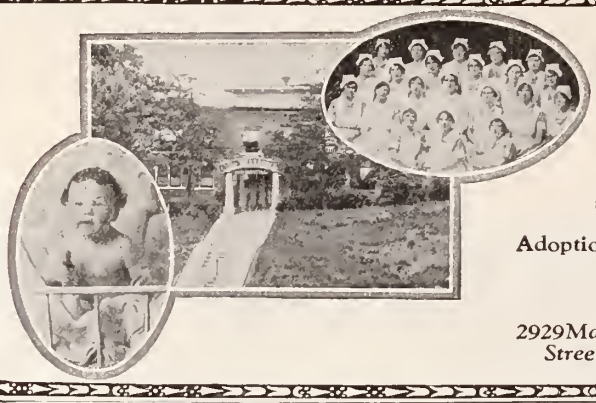

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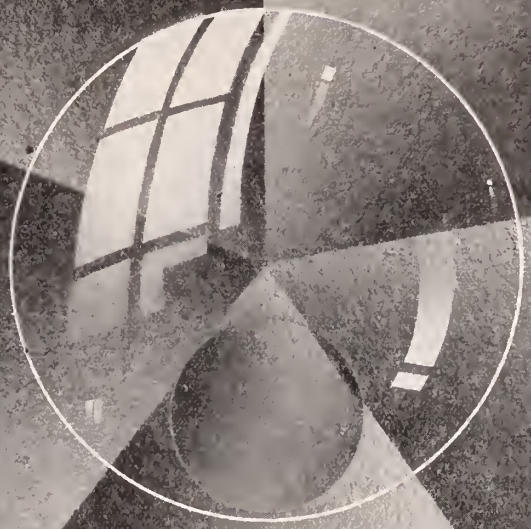

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The Wisconsin Medical Journal

Volume XXX NOVEMBER, 1931 No. 11

Congenital Hemolytic Jaundice

By LOUIS M. WARFIELD, M. D.
Milwaukee

In 1885 Murchison[1] published a case of an interesting disease characterized by anemia, splenomegaly, jaundice with no manifestations of biliary intoxication. He gave it the name of chronic acholuric jaundice. This would appear to be the first time this association of symptoms was described. There seems to be no doubt that Murchison described the disease now known as congenital hemolytic icterus. In 1887 Sir Spencer Wells[2] removed the spleen of a patient evidently suffering from this condition. It was not until 1900 that the disease was differentiated from the many conditions giving chronic jaundice and was considered a separate entity.

The disease occurs in two main types the congenital or familial type (some divide this type into two) and the acquired form. The former is known sometimes as the Chauffard–Minkowski type, as it was described in detail by these two investigators; the latter is known as the Hayem–Widal type for a similar reason.

Hemolytic jaundice is not a common disease but it is by no means a rarity. Up to 1914 Elliott and Kanavel[3] could collect but 47 cases and added one of their own. At present there are more than 200 cases in the literature alone.

One of the most comprehensive reports is that of Thayer and Morris[4] in 1911. They reported two cases but stated that there was no history of jaundice in the family of either case. Their report concerns the acquired hemolytic type. They say that the syndrome has followed various diseases and severe nervous shock. Other cases appear to arise spontaneously. It comes on in adult life. Banti has divided it into primary and secondary. The former arises without apparent cause or during the course of some disease, the latter is observed as a transient condition, associated with acute infections, poisons, or as a terminal phenomenon in the course of some chronic disease.

The acquired disease may occur in several different forms:

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3. Simulating a chronic infectious cholangitis, chronic infectious splenomegalic jaundice (Hayem).
4. Also observed in some of those conditions in which the most striking symptoms, anemia and splenomegaly, leave one in doubt as to whether the case should be classed clinically as Banti's disease or as a cirrhosis of Hanot type.

In congenital hemolytic jaundice there is a definite family history of the disease. No one has traced the history farther back than three generations. The cases begin in early life and do not as a rule limit the subject's activity or impair his health materially. As Chauffard has remarked it is more esthetic than disease. However as the subject grows older there are attacks of pain over the liver or gall bladder, fever, prostration, and a temporary increase in the jaundice. The spleen is apt to increase in size. Following the attack the patient recovers, and except for the persistent slight yellow color of the skin, is quite well. In the interval between the attacks examination shows an enlarged hard spleen, jaundice, anemia more or less, urobilinogen in the urine, and a peculiar fragility of the red blood cells to hypotonic saline solution. This last is true of all the congenital forms but may or may not be present in the acquired forms. A striking fact about the fragility is that although after splenectomy the jaundice clears, the urine clears, the fragility remains. In Sir

Spencer Wells' case the patient was alive 27 years after the operation but his cells still showed increased fragility. This is the longest reported case. Many cases are reported where the fragility was present from one to seven years following clinical cure of the patient. Naturally such a striking phenomenon has received much attention but the only explanation given has been that it is a defect in the stroma of the red cells caused by some anomaly in the bone marrow. Why the defect should persist, yet the patient be perfectly well, is still a mystery. What causes the jaundice? Opinions differ. Some believe as Chauffard, Minkowski and Vaquez do, that the corpuscles are abnormally fragile to begin with and are too readily destroyed in the spleen. Others, following Widal, believe that destruction takes place in the general circulation and the debris accumulates in the spleen. With the present conception of the reticulo-endothelial system it would appear that it is more likely that this system, concentrated in the spleen, destroys the peculiarly fragile cells. The bone marrow is tremendously active, pouring out young cells. This activity has been found in both the acquired and the congenital forms. Reynolds[5] reports a case of acquired hemolytic jaundice in a man of 21. The duration was 17 months. There was marked jaundice and both liver and spleen were enlarged. The fragility index was normal (.44 to .20% NaCl). There were 92% of reticulocytes. Clinical cure followed splenectomy. Three years later the blood count was normal, the fragility index was .40 to .25% NaCl and only 0.9% of reticulocytes.

In some contrast to this is the report by Baty[6] of congenital hemolytic jaundice in a child (male) 3 years old. The red cells were 1,200,000, Hb. 30 per cent. Reticulocytes 92%. The liver as well as the spleen was enlarged. Two years after splenectomy and a clinical cure the reticulocytes were still from 30 to 70 per cent.

CONGENITAL VS. ACQUIRED TYPES

Apparently then there is a difference of a more or less profound grade between the congenital and acquired types. The congenital type has a definite hereditary basis. It begins early in life. The course is characterized by attacks of pain, fever, anemia and increasing jaundice. Fragility of the red cells is diagnostic and characteristic and although the patients are clinically cured by splenectomy the anomaly of the red cells persists for years, probably for the life of the individual. The reticulocytes also appear to be always increased. This would indicate that there is abnormal destruction of red cells even though the spleen is removed and constantly increased bone marrow activity. Sauer[7] considers that the chief anomaly is to be sought in the corpuscles themselves and the main seat of destruction is in the spleen.

In the acquired type the onset is in adult life. Many diseases may bring it on. Increased fragility of the red cells, so characteristic of the congenital type, is not always present. Reticulocytes are increased during the jaundice but return to normal following splenectomy. (This may not prove to be true when more cases are studied).

Gall stones are present in 58% of cases. This association of gall stones with the jaundice has led some to question the entity of the disease. However, cases are on record, for example that of Richards and Johnson,[8] where gall stones were removed at operation but the spleen not removed. The woman did not lose her jaundice but the acute attacks ceased.

Splenectomy is an absolute cure. The first reported case where the operation was purposefully done to cure hemolytic jaundice was that by Banti[9] who in 1912 published his case which was splenectomized in 1903. Thayer and Morris in 1911 did not have their cases operated upon but gave them iron. The cases improved but did not lose their jaundice. In 1915 Goldschmidt, Pepper and Pearce[10] studied the iron metabolism of a case of congenital jaundice. They found a large loss of iron through the feces before splenectomy and a decided decrease in iron output after operation. Urobilinogen and urobilin in the feces were also much diminished after splenectomy.

CASE REPORTS

I wish to report three cases, all observed some years ago. Two were of the congeni-

tal type and one of the acquired type. All were splenectomized and all lost their jaundice in a few days. One lived fourteen years in good health and died of influenzal pneumonia. The other two are still alive and well, one eleven and one thirteen years after splenectomy.

CASE I

On December 20, 1916, I saw in the office a young girl 19 years old, unmarried, whose occupation was hairdressing. She complained of pain in the left side, slight yellowish tinge to the skin which varied in intensity from time to time. Otherwise she was well and at work every day.

In the family history (Chart I) the grandfather on the father's side was said to have had liver disease for many years, the skin was yellow and he was quite trembly. The patient's parents are cousins related through the mother. The patient's father has been yellow for many years, he enjoys good health, but was said to have had liver disease which was not known to be present during boyhood. One uncle and two aunts of patient had yellow skin for years but the whites of the eyes were not known to have been yellow. Two uncles and one aunt were apparently quite normal. One sister, aged 29, has been of a sallow color for many years, she has a large spleen. Following the birth of a child, a girl, she became much worse. The child was yellow from birth up to two years old when it died of dysentery. Nothing was known about its spleen.

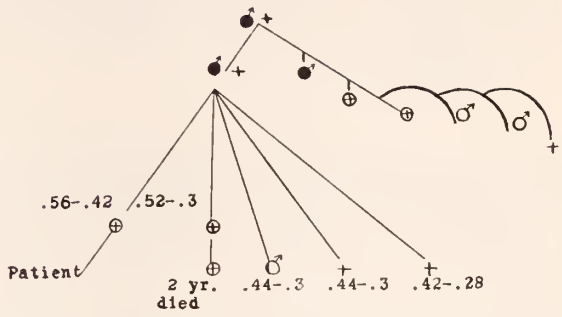
The patient had had no serious illnesses except typhoid fever when she was 3 years old. At that time she was noticed to be jaundiced. She has been yellow off and on ever since then. Menstruation began at 11 years and has always been regular with a normal flow and no pain. For the past 10 years she has been perfectly well. Her appetite is good, bowels regular, urination normal.

The present illness began about 3 weeks before I saw her, with a slight cold and sudden, sharp, knife-like pain in the left side. This ceased for two weeks, then returned. There was no cough, no fever, she felt well except that she could not take a deep breath without pain.

On examination she was a well developed and well nourished girl 5 feet 5 inches in height and 120 pounds in weight. The flesh was firm and the skin texture normal. The skin was universally a light yellow color and the conjunctivae were slightly yellow. The mucous membranes were pale. The tongue was clean, the teeth and pharynx normal. Temperature was 99° F., pulse 96 regular. Nothing abnormal was found in the lungs or heart. The abdomen was flat with slight fullness in the left hypochondrium. A smooth tumor with shape of the spleen extended from beneath the left rib margin to the level of the umbilicus and to the mid-line. It was smooth, firm and somewhat tender on palpation. In order to prove that this was her spleen

Family Tree of Patient

Chart I



Black circle males are those with jaundice.
Unblacked circle males are those without jaundice.
Circle around female legend are those with jaundice.

and not her kidney the large bowel was distended with air. The tumor mass was found to lie in front of the colon. The liver was not enlarged. At the reflexes were normal.

The urine (catheterized) was dark reddish in color, acid, 1022 sp. gr., contained neither albumin nor sugar but reacted very positively to urobilinogen and indican.

The Wassermann reaction of the blood was negative. The first blood count showed Hb. 58 per cent (Sahli), red blood cells 3,552,000, leucocytes 12,000. The differential count was 68 per cent polys; 16 per cent basophiles; 1.2 per cent eosinophiles; 24 per cent small and large lymphocytes; 5.2 per cent endotheliocytes. "The red cells are not much changed in size although there is some distinct irregularity. There are a number of nucleated cells, mostly normoblasts. One megaloblast is seen. There is considerable polychromatophilia and some granular degeneration in the red cells with many pyknotic nuclei."

Resistance of the red cells to hypotonic saline was tested on Jan. 19, 1917. Initial hemolysis at 0.5 per cent, complete at 0.46 per cent.

As this settled the diagnosis of congenital (familial) hemolytic jaundice, splenectomy was advised. On April 21, 1917, Dr. J. L. Yates removed the spleen and the gall bladder. The latter was distended, contained clear viscid mucus and there were several small stones imbedded in the cystic duct. The common duct was free.

The spleen weighed 820 grm., was smooth, was a dark steel blue color and the consistency was somewhat soft and leathery. It cut with resistance, the surface showed marked increase in trabeculae with very few structures resembling malpighian corpuscles which were at one end only.

Microscopic sections from the spleen showed the pulp packed with red corpuscles. The sinuses were dilated and full of red cells. Everywhere was seen increase in connective tissue in the form of young fibroblasts and young fibrils. The trabeculae were not increased in thickness. The process was intrasplenic in the pulp itself. The few Malpighian

corpuscles seen were small, the centers showed proliferation of cells. The arteries were the seat of extensive endarteritis amounting at times to complete obliteration of their lumina. Professor Bunting called this the early stage of Banti's disease.

(For detailed data see charts)

CASE II

In 1920 I saw in consultation a boy at Columbia Hospital, Milwaukee, who was then 11 years old. Since he was 1½ years old he had been of a lemon yellow color. He was the only child and there was no family history of jaundice obtainable. He has had several attacks of fever, vomiting, weakness with increase of jaundice. The spleen was enlarged, white cells 13,100, reds 2,190,000. Hb. 38 per cent. Wassermann reaction was negative. The fragility index was .57 to .42%. No urobilin was found in the urine. (This observation is difficult to believe as all acholuric jaundice cases have urobilin in the urine). Splenectomy was performed by Dr. E. H. Mensing who with Dr. M. F. Rogers reported this case. Word from this man recently was that he was in Texas, working daily and was perfectly well.

In spite of the lack of family history this case corresponds to the congenital type and is so included here.

CASE III

On Feb. 14, 1918, I saw a young white man then aged 25 who complained that for the last three years he had been continually jaundiced. There were periods of increasing jaundice accompanied by attacks of pain over the liver often with fever. He always felt below par so he consulted a doctor March 17, 1917, who diagnosed gall stones and advised operation. He was told that at the operation no stones were found but that there was stenosis of the common bile duct. The cystic duct was clear. The fundus of the gall bladder was anastomosed to the duodenum, a cholecystoduodenostomy. The patient survived the operation but did not lose the jaundice.

Physical examination revealed a tall, slender young man with a general light yellow tinge of skin and conjunctivae. The chest organs were normal. The abdomen was flat, a scar about 12 cm. long extended down the right costal border at the outer edge of the rectus muscle. The liver was not palpable. The spleen was easily palpable, firm, rounded edge and extended 10 cm. below the costal border. There was no definite history of jaundice in his family. Both parents were free from jaundice. One brother and one sister were well. The sister was examined and found to be normal.

The laboratory tests showed Hb. 65 per cent, reds 5,280,000, white cells 8000. The differential count showed polys 51.6%, eosinophiles 0.8%, basophiles 0.4%; large and small lymphocytes 35.2%; large mononuclears 12%. The red cells showed considerable variation in size but no poikilocytosis. No nucleated red cells were seen.

The urine was dark reddish, there was neither albumin nor sugar but it contained a large amount of urobilinogen. The hemolytic index of the red cells was 0.5 to .38%. He was urged to have his spleen removed but refused. I saw him again on Dec. 7, 1920. In the meantime he had been to the Mayo Clinic in April, 1918, and had had his spleen removed. He was quite well until June, 1920, when he began to have intestinal indigestion, constipation, nervousness and loss of weight. The jaundice had cleared about a week after operation and had not reappeared. At this time the edge of the liver was palpable. Barium was given by mouth. In brief, the stomach was cowhorn shape, the cap normal. Just to right of the mid-line after 6 hours was a small mass of barium above which was a light shadow and above this an air bubble. It looked like the outline of the gall bladder but on further study it was thought to be a large duodenal diverticulum.

The blood count showed Hb. 70%, reds 2,860,000, whites 11,400. The red cells were somewhat uneven in size and shape. The hemolytic index was .4 to .3%, a normal figure.

On Sept. 12, 1922, his Hb. was 85%, reds 5,252,000, whites 9,800.

He was not seen again until Feb. 9, 1927, when his blood count was Hb. 95%, reds 5,600,000, whites 9,000. He was still complaining of his bad stomach, constipation and weakness. The urine was normal. He was seen off and on up to Nov. 20, 1929, when he left for Montana.

DIFFERENTIAL DIAGNOSIS

The differential diagnosis is not difficult if one keeps the disease in mind. From pernicious anemia with jaundice, the diagnosis should not be difficult. Increased fragility of the red cells is never present in pernicious anemia and the spleen is not apt to be enlarged. Blood smears may be something alike in the two diseases but no one with any experience should confuse the two blood smear pictures. From so-called Banti's disease, cirrhosis of the liver with splenomegaly and anemia of a chlorotic type the diagnosis may be a little confusing. In such cases the skin is not infrequently slightly lemon tinged and acute attacks of pain and fever may occur. Here again the increased fragility of the red cells is diagnostic. The family history will also be helpful in diagnosis.

In the South and in the Tropics chronic malaria may enter the differential diagnosis. If no parasites can be found, again the increased fragility of the cells will establish

CHART II

Fragility tests of family of patient F. M.

Number	Relation	Beginning Hemolysis	Complete Hemolysis	Remarks
Miss M.	Sister	.44% Na cl	.3% Na cl	Quite well
A. M.	Brother	.44% Na cl	.3% Na cl	Quite well
Mrs. F.	Sister	.52% Na cl	.3% Na cl	Jaundiced—enlarged spleen
E. M.	Sister	.42% Na cl	.28% Na cl	Well
Mrs. M.	Mother	.44% Na cl	.28% Na cl	Well
F. M.	Patient herself	.54% Na cl	.42% Na cl	March, 1918. Quite well

CHART III

Date	Hb	Reds	Leuc.	Differential Count						Fragility Corpuscles	Remarks
				P. M. N.	Eos.	Bas.	Lymph. l.	L. Mon.	Nuc. Reds		
12-21-16	58%	3,552,000	12,000	68%	1.2%	1.6%	24%	5.2%	Normoblasts		Urobilinogen in urine and blood serum
1-19-17										.5% to .46%	
4-21-17											Splenectomy
5- 1-17											No urobilinogen
5-12-17										No hemolysis .56% to .34%	Feels weak. Pain in abdomen after eating.
5-17-17										No hemolysis .5% to .3%	Friction rub and fever.
5-28-17			15,000	80.2	.4	.6	10.6	8.2			Pneumonia.
7-10-17										.8 to .7%!!	Pt. feels well. No jaundice. Is working.
9-19-17	98%	6,252,000	6,000	56.8	2.6	1.2	24.	15.4	None	.72 to .56%	No urobilinogen. Feels fine.
11-20-17	98%	5,576,000		68.	2.4	0	15.2	14.4	None		Occas. dizzy feelings.
3- 8-18										.54 to .42	Pt. quite well.
3- 3-19										.5 to .44	Pt. quite well.
5-15-28	100%	4,272,000	13,100	61	0	0	41	0	None Normal cells		No urobilinogen.
7-20-28										.42 to .36 1½ hr. .46 to .40 18 hrs.	Remained well past 9 years. No urobilinogen.
1-14-31											Pt. died influenzal pneumonia in another city. Information from brother.

the diagnosis. In all other diseases simulating congenital hemolytic jaundice none has this peculiarity of the red cells. The test is not difficult to perform and should be done whenever there is a suspicion of the disease in question.

TREATMENT

Little need be said about treatment for there is a specific cure—splenectomy. Occasionally the adhesions between the capsule and the under surface of the diaphragm or the parietal peritoneum make the operation difficult. There should be no mortality in the hands of a skilled anesthetist and a skilled surgeon. Once the spleen is removed the anemia rapidly disappears, but the peculiar reaction of the red cells to hypotonic salt solution may remain for years. Iron in some form is advisable in order to aid in the more rapid return of hemoglobin.

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The Goiter Heart*

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When approaching a study of heart disease associated with a condition having such a profound influence upon the circulation as hyperthyroidism, several points of unusual interest immediately arise. The incidence of cardiac disturbances, their effect upon operability and mortality and the future course of such conditions are questions all of which are most pertinent.

The present study comprises observations on a group of 327 consecutive patients with hyperthyroidism covering a three-year period. This number includes both exophthalmic goiters and toxic adenomas. For comparison these two groups have been studied separately. In the exophthalmic goiter group there were 242 cases, 236 of which were operated on, and 6 which were not operated on. Of the toxic adenomas, 73 were operated cases and 12 non-operated. No patient was refused operation and several of the patients were in a very advanced stage of hyperthyroidism.

Tachycardia is a necessary accompaniment of hyperthyroidism, meeting the demands of the tissues resulting from increased metabolism. Premature contractions were encountered six times in each group and no special significance was attached to this occurrence. Cardiac murmurs occurred in approximately one-fifth of both groups. The majority of these were systolic murmurs at the apex. In most instances the murmurs are relative rather than absolute and are due to a stretching of the valve orifice from dilatation of the ventricle. Heart block occurred in one patient two years after operation for an exophthalmic goiter. Cardiac hypertrophy, when associated with hyperthyroidism, is probably due to increased work rather than to the toxemia.

The pulse pressure in both the exophthalmic goiters and the toxic adenomas was considerably increased above normal. In exophthalmic goiter this was due to a slight elevation in the systolic blood pressure and a more decided fall in the diastolic. The average systolic blood pressure was 144, the diastolic 69, and the pulse pressure 75. The increased pulse pressure in toxic adenomas was the result of a moderate increase of systolic pressure, the average being 173, with a slight increase in the diastolic pressure, 89, producing a pulse pressure of 84. Hypertension is much more commonly associated with toxic adenoma than with exophthalmic goiter.

Although no single condition typifies the goiter heart, auricular fibrillation is the most outstanding cardiac abnormality associated with hyperthyroidism. This fact should always be borne in mind when auricular fibrillation is discovered in a situation unrelated to hyperthyroidism. An acute condition may so definitely overshadow an existing hyperthyroidism that the latter might readily be unrecognized if attention were not so directed through the presence of auricular fibrillation. This association is of greater incidence in patients below 40 years of age, because in this age group auricular fibrillation is relatively rare, when unassociated with exophthalmic goiter or mitral stenosis.

Auricular fibrillation occurred in 9.5 per cent of the cases of exophthalmic goiter, and 32 per cent of the cases of toxic adenomas. Of these 23 cases of auricular fibrillation occurring in exophthalmic goiter, 17 were constant, 2 were intermittent and 4 transient. Constant fibrillation occurred in 17 of the 27 cases in toxic adenomas, intermittent fibrillation in 4 and transient in 6. A comparison of the age, basal metabolism, duration of symptoms in the cases of auricular fibrillation with exophthalmic goiter in the entire series revealed that although the average age of all of the patients was 38.9 years, in the cases of auricular fibrillation it was 54 years. In the latter instance the duration of symptoms was 9.6 months as compared with six months for the entire groups. Only

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slight variation occurred in the basal metabolism, 50 per cent for the general average and 54.8 per cent in the auricular fibrillation group.

The average age of the entire toxic adenoma cases was 54, the basal metabolic rate +36 and the duration of symptoms 11.8 months. In the cases of auricular fibrillation in this group, the age was 61, the basal metabolic rate +46, and the duration 10 months.

From these studies it appears that the development of auricular fibrillation in exophthalmic goiter was dependent upon two factors, (1) age, (2) the duration of symptoms. The intensity of hyperthyroidism seems to play a less important part.

The age factor exerts the same influence in the cases of toxic adenomas as in exophthalmic goiter. Conversely, there is a reversal in the importance of the degree of toxicity and the duration of the disease. One explanation can be given for this. The hearts of a series of persons averaging 39 years of age can withstand the onslaught of hyperthyroidism for a longer period of time than can those 54 years of age.

The factor, then, which stands out more definitely than any other is the age. Both exophthalmic and toxic adenomas are more liable to produce auricular fibrillation in the cases developing hyperthyroidism at the time of life when degenerative changes in the heart usually occur. This explains the greater incidence of auricular fibrillation in the group of toxic adenomas.

Evidence of congestive heart failure was present in 43 per cent of the cases of auricular fibrillation in the exophthalmic goiter group, while only 2.7 per cent of cases other than auricular fibrillation in this group presented signs of congestive heart disease. This condition was found in nearly 50 per cent of the cases of auricular fibrillation due to toxic adenomas and in 6 per cent in the remainder of the group. In the group of exophthalmic goiter, there were 6 patients who were not operated on, none of whom died.

Of the 236 patients operated on, 7 died (2.9 per cent). Exclusive of the cases of auricular fibrillation the mortality was 2 per cent. All of the 23 patients with auricular fibrillation were operated on with 2 deaths (8.7 per cent). Death in both instances was ascribed to cardiac failure.

Seventy-three patients with toxic adenoma were operated on. Of the 12 not operated on, none died. The total operative mortality was 8.3 per cent (6 patients). Exclusive of the 5 deaths in the auricular fibrillation group the mortality was 1.3 per cent. While the operative mortality is high, operation was only attempted as a last resort in several cases. A thyroidectomy was performed on 25 of the 27 patients with auricular fibrillation. Five of these patients died making a 20 per cent mortality for this group. Two died from cerebral embolism. In both instances embolism occurred while the heart was under the influence of digitalis and while fibrillating.

One patient died in an apparent toxic psychosis. One died of cardiac failure and one of anoxemia. In many instances death following thyroidectomy is attributed to cardiac failure, the extremely rapid pulse, often irregular, with the dyspnea, cyanosis and mucus in the throat are considered as evidence of a failing heart. As Willius pointed out, the cardiac phenomena under such circumstances are secondary to an anoxemia often of slight degree but contiued over a considerable time. He mentions the fact that Asher has demonstrated that animals rendered hyperthyroid by feeding thyroid extract are extremely susceptible even to a slight decrease in the concentration of the oxygen in the inspired air. Injury to the recurrent laryngeal nerve producing partial obstruction of the larynx together with the accumulation of mucus is probably the most common cause of anoxemia.

Of the 41 cases of auricular fibrillation of both groups which survived operation, 4 were not seen again after leaving the hospital. Recurrence of an exophthalmic goiter four years after the first operation caused a recurrence of the auricular fibrillation in one case. The fibrillation in another patient, which was controlled postoperatively with digitalis, recurred four years later. There was a persistence of the fibrillation in 4 others in spite of digitalis and quinidin.

The fibrillation in the remaining cases either disappeared spontaneously or was controlled by digitalis or quinidin.

Auricular fibrillation in the absence of signs of advanced congestive heart disease does not preclude operation in cases of hyperthyroidism. In many instances it is impossible to establish a normal rhythm with either digitalis or quinidin until the hyperthyroidism has been controlled. A surgeon is reluctant to operate upon a patient with any condition other than thyroid disease in the presence of auricular fibrillation; but with hyperthyroidism it is a question of removing an exciting cause, thereby relieving the heart of its toxic load.

Of the 7 deaths in the series of 48 operated cases of hyperthyroidism in which auricular fibrillation occurred, three were attributed to cardiac failure. A higher death rate must be expected in these patients. Although congestive heart failure occurs in nearly 50 per cent of the patients with auricular fibrillation and hyperthyroidism, and in spite of the fact that the cases may seem desperate, with proper care better results with regard to life and future effectiveness may be expected with operation than without.

USE OF DIGITALIS

A few years ago Plummer stated that following the discontinuance of digitalis in the routine preoperative preparation of toxic goiter, a considerable reduction in mortality occurred. As a result many surgeons have given up using digitalis although many more continue to use it.

In a questionnaire sent out by the Jackson Clinic to 50 American and European surgeons three years ago, the following question was incorporated, "Is digitalis used in the preoperative care of exophthalmic goiter and toxic adenomas?"

The following replies were received:

Exophthalmic goiter--yes, 17, in selected cases
Toxic Adenomas------yes, 21, in selected cases

To the question, "Is digitalis contraindicated in the preoperative care of toxic adenoma?"

6 replied in the affirmative.
19 replied in the negative.
7 were questionable.

In our experience some deaths have resulted whether or not digitalis was used and this was the opinion of the majority who answered the questionnaire.

Patients with auricular fibrillation whose hearts are compensated are digitalized preparatory to operation. The operation is then performed in spite of the fibrillation which frequently persists.

The patients with auricular fibrillation and congestive heart failure must necessarily be subjected to a period of careful preoperative treatment. This includes rest in bed, restriction of fluids, a salt-free diet, digitalis, ammonium chlorid or ammonium nitrate, merbaphen intravenously or intramuscularly, and sedatives, phenobarbital, bromides or pantopon. A high caloric diet and Lugol's solution must be included in this regime.

Quinidin is the most effective drug in the treatment of paroxysmal and permanent auricular fibrillation. In some instances the continued use of digitalis in paroxysmal auricular fibrillation will lengthen the interval between attacks and decrease their severity; with the continued use of small daily doses of quinidin there is a greater probability of abolishing the paroxysms. Far greater success results from the use of quinidin in permanent auricular fibrillation than with digitalis. Digitalis will lessen the rate and abolish the pulse deficit; in only a small percentage of instances will it abolish the irregularity. Quinidin, should, of course, not be used in the presence of congestive heart failure. In these cases the heart should first be restored to normal compensation.

The possibility of embolism occurring in auricular fibrillation is always eminent. This applies to untreated cases as well as to cases under treatment both with digitalis or quinidin. Although embolism is most liable to occur at the moment that a sinus rhythm is established, it may occur while the auricles are fibrillating when the contractions of the heart have become more vigorous from the influence of digitalis. Two instances of this were seen in this series. There are no means of foretelling with surety whether embolism may be expected to occur in a given case when considering quinidin therapy. Fluoroscopy of

the heart, however, does afford a means whereby one can select with greater care patients for this type of treatment. If there is active contraction and relaxation of the heart, the possibility of the auricles containing thrombi is considerably less than when the muscular action of the heart is feeble. A previous history of embolism is always a contraindication to the use of quinidin.

SUMMARY

1. A study of a series of 327 patients with hyperthyroidism with special reference to the heart is presented.

2. There were 242 patients with exophthalmic goiter and 85 patients with toxic adenoma.

3. Auricular fibrillation was present in 9.5 per cent of the cases of exophthalmic goiter and in 32 per cent of the cases of toxic adenoma.

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Cervicitis

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Viroqua

Cervicitis is important not only because of the distress and disability it causes, but because it may lead to cancer, puerperal or pelvic infection or may be the focus of infection.

About 13,000 (1) women die in the United States each year from cancer of the cervix. This is 16.5% (2) of all cancer deaths in females. Proper treatment of the predisposing cervicitis is the best security against cancer. This is shown by the fact that in 669 cases of cancer of the cervix Smith (3) found only 12 had had trachelorrhaphy, none had had amputation or cauterization and on the other hand in 5,962 trachelorrhaphies, amputations and cauterizations only 5 were found to develop cancer and all those were in the trachelorrhaphy group.

Between 75% (4) and 85% (5) of all women have "ulcer" of the cervix. It is found about three times as often in multipara as in nullipara.

The infected cervix not rarely is a source of systemic debilitating disease, anaphylactic phenomena, or progressive arthritis. Where other sources of focal infection, as teeth, tonsils, and sinuses can be eliminated, the cervix should be investigated. (10)

I prefer to discuss this lesion as cervicitis instead of endocervicitis because the vaginal mucous membrane and the deep fibrous, muscular and glandular parts are usually affected as well as the endocervical lining. The lesion has been called erosion, pseudoerosion, ectropion, eversion and ulcer.

In this paper I will present the data from fifty selected cases treated in a country practice during 1928 to 1930.

DEFINITION

Cervicitis is an inflammation of the cervix uteri from birth trauma or microbic infection, with hyperplasia and protrusion beyond the external os of the columnar endocervical lining and downgrowths of the racemose endocervical glands giving symptoms of leukorrhea, backache, etc., and leading to cystic degeneration and in time to cancer and demanding treatment with cautery or scalpel to cure.

ETIOLOGY

About 75% of cervicitis is found after childbirth. In my series 80% were parous. The degree of laceration and injury is not as important as the virulence of the infection that supervenes. The most important organisms are gonococcus, staphylococcus, streptococcus and colon bacillus, though infections are often manifold and mixed especially in the parous. Trichomonas is often associated.

A few rare cases may be considered as congenital, coming from a persistence of the anomalous foetal endocervical tissue. Con-

genital lesions are non-inflammatory, non-infectious and non-irritating and usually heal at puberty. (6) In children, diphtheria, scarlet fever, specific vulvovaginitis or general debilitating diseases may lower the resistance of the endocervical tissue and increase susceptibility to mixed infection. I have one case to report that definitely dates her leukorrhea to scarlet fever at 9 years of age.

Table 1. Etiology: ages 18 to 50—average, 27.2 years 19 Primipara—average, 4.5 children each.

Congenital or childhood infection	4	7.7%
Acute Gonorrhea	4	7.7%
Chronic Gonorrhea	4	7.7%
Birth Trauma	40	77. %

ANATOMY

The normal cervix is a fibromuscular structure about the size of a walnut (35 mm. in diameter) half of it extending into the vagina and covered with flat squamous epithelium. It is pierced by a splindle-shaped canal about 1⅜ inches long and the size of a match in nullipara and of a pencil in multipara. This is lined with folds of single-layered cylindrical epithelial cells and down from which racemose mucous glands extend.

PATHOLOGY

Acute inflammation of the cervix is not usually seen except in gonorrhea because it is obscured by, and treated as, the more serious associated lesions, metritis or salpingitis or cellulitis occurring in post-partal or post-abortal infections. The bacterial invasion produces swelling, edema, vascular engorgement and leukocytic infiltration with rubor, dolor, calor and tumor. The epithelium becomes macerated and is desquamated leaving a red, raw, bleeding, ulcerated area. The racemose glands become infected and swell and secrete mucus profusely.

In the subacute stage the inflammation has subsided. There is less exudate and new epithelium forms from the columnar cells of the glands which are more active in the presence of the lessened irritation than the squamous cells. Therefore there is a protrusion of this raised velvety new epithelium outside the external os. The glands grow down deeper into the fibromuscular cervix. This is the stage of proliferative repair reaction of the endocervical epithelium to the less virulent irritation.

In the chronic stage the irritation and inflammation has subsided greatly and the squamous epithelium tries to grow back over the protruded endocervical epithelium, but each menstruation, instrumentation, coitus or pregnancy increases the congestion and the tissues are in a state of see-saw warfare and it is in this state that the abnormal cell proliferation of cancer is wont to arise. There is a rarefaction and scarring of the fibromuscular tissue and the glands penetrate deeper and dilate slightly. If the tissue resistance is great enough to overcome the mild irritation remaining, healing will result and the squamous epithelium will grow over the old erosion, but will close the ducts of the glands which will dilate and become Nabothian cysts. Cancer is not so apt to develop if progress is made to this healing stage. (7)

Table 2. Associated Pathology: size of erosion 3 to 35 mm. average 18.5 mm.

Laceration	20	40%
Retrodisplacement	12	24%
Cystic degeneration	12	24%
Prolapse	6	12%
Acute Anteflection	3	6%
Cervical Polyps	2	4%

SYMPTOMS

Leukorrhea is the cardinal symptom. It may be mild, and clear mucus noticed only after menstruation; or may be a profuse purulent discharge requiring the constant wearing of a pad. In my cases 88% had leukorrhea and 66% gave it as the primary symptom. Backache is the next most common complaint: 48% in my cases—20% as primary symptom. The backache is usually sacroiliac or lumbo-sacral in location but is not increased by compression of the pelvis or by bending, but is exaggerated by menstruation and exertion. Pelvic distress of various kinds is often found. Other symptoms given are dysmenorrhea dyspareunia, sterility, nervousness, frequency and constipation.

The local inflammation, secondary parametritis and lymphadenopathy cause the dysmenorrhea and dyspareunia as well as the backache. The absorbed toxins from the infected glands cause anemia, debility, genital neurosia, asthma and other anaphyl-

actic phenomena. In determining need for treatment the pathology must be considered more than the symptomatology.

Table 3. Symptoms:	*Primary*		*Secondary*	
Leukorrhea	33	66%	11	22%
Backache	10	20%	14	28%
Pelvic Distress	1	2%	7	14%
Dysmenorrhea	2	4%	1	2%
Dyspareunia	—	—	4	8%
Nervousness	1	2%	6	12%
Sterility	1	2%	4	8%
Constipation	1	2%	3	6%
Frequency and Dysuria	1	2%	3	6%

TREATMENT

Treatments with douches, topical chemical agents, medical diathermy or foreign protein injections are not very satisfactory except in mild cases. (8) Autogenous vaccines help some. Curettage is good in some hands in certain cases. Radium is too dangerous because of infection, stenosis or sterility, especially in the hands of those usually called upon to treat cervicitis. Intrauterine mercury ionization helps if there is a predisposing endometritis. (9) Resection or conization as by the Strumdorf method is good if beyond the child-bearing period and in bad cystic conditions. Most of the cases can be cured readily by endothermy conization, fulguration, or cautery. The most effective and also the simplest method is 4 to 8 cuts with a nasal or similar cautery.

The usual procedure in my cases has been that at the first visit a complete history was taken and a general examination made. If indicated by bleeding or vegetations a biopsy was taken with a nasal punch or curved scissors, and the bleeding and possible spread of malignancy stopped by fulguration. Treatment was usually limited to the application of one of the stronger chemical cautery agents, such as silver nitrate. A few mild and shallow cases were helped and infections were reduced in the more severe cases, rendering subsequent cautery safer and less liable to produce systemic reactions from the absorbed toxins. Often several treatments of various chemical agents were given until other conditions could be relieved or until arrangements could be made for complete cautery.

If the patient was dubious as to the need of further treatment, showing her the size of the "sore" with a hand mirror was usually quite convincing.

I have been advising treatment of most erosions seen early in pregnancy. If care is used there seems to be no danger of abortion, and a potent source of puerperal infection is removed.

Some phlegmatic women require no anesthetic. Very nervous individuals were given one and one-half grains (1½ gr.) of luminal the night before treatment, repeated on arising and three to six grains 1 to 3 hours before treatment, or morphine sulphate one-quarter grain (¼ gr.), with atropin one one hundred fiftieth grain (1/150 gr.) or scopolamine one one hundredth grain (1/100 gr.) added if indicated. Some require general anesthetic and then nitrous oxide-oxygen is used. When the cervix is very sensitive local infiltration is used. Novocaine ½%, 20 cc. injected 2 inches into each broad ligament while withdrawing the needle was very satisfactory. Most cases, however, were relieved of pain by topical application of 10% cocaine to the area to be cauterized. The vaginal walls were sprayed with 1% butyn solution to protect against feeling the heat of the cautery stem. The limits of the erosion can be made very plain by painting with tincture of iodine; the vaginal squamous epithelium staining very dark compared with the redundant columnar cells. The iodine also serves as an antiseptic. The mucous is removed with peroxide or strong sodium hypochlorite solution and the cervix swabbed dry with cotton.

With the hot wire cautery, nasal cautery or Post cautery, 4 to 8 lines or cuts were made about 3 to 5 mm. deep from the internal os to the edge of the eversion.

If the wire is inserted cold to the internal os and withdrawn slowly and the right amount of current applied, the wire will coagulate about 1 mm. and will not stick to the tissues or burn so rapidly as to cause bleeding. Heat at the internal os causes pain and cramps.

With a diathermy machine, either the bipolar or monopolar (Tesla), fulgurating currents can be used equally well and with the needle-tipped electrode lines made similar to those made with the nasal cautery. It is the best to experiment with a piece of beef and find how much current you want to use and

even then you will have to judge carefully when each area is being cauterized by the amount of coagulation and sputter. The smallest effective spark gap gives the least pain. A weak current will cauterize deeper and better but will take more time—up to 20 seconds for each location of the electrode is best. A strong current will char the surface, will not penetrate, and is more apt to bleed. The foot switch should be used. Each cyst should be punctured and fulgurized thoroughly.

The actual cautery, as with a soldering iron, has much to be said in its favor even if antiquated. The old Pacquelin blade, while mechanically out of date, has healed many cervices. The bacteria are killed directly by the heat and indirectly by the hyperemia.

Dr. A. A. Skemp demonstrated some very good results obtained by heating the tips of an ordinary uterine dressing forceps in a flame and dilating the cervix. A modification of the ordinary electric soldering iron has been used, but unless the patient is under general anesthesia, the heat from the shaft is too painful. I have lately been using a screw cautery which I devised. The tip has a coarse spiral thread on a thick shaft 1 inch long and with a large head. (Fig. 1) This is heated to about 400° centigrade in boiling vaseline and plunged or screwed into the anesthetized cervix and allowed to cauterize until cooled. As it is withdrawn the coagulated tissue is caught in the threads and removed, lessening the danger of hemorrhage and the absorption of toxins from the necrotic tissues. The hollows between the ridges of the screw threads leave areas not cauterized so deeply, like the bridges left between the lines of a nasal cautery for subsequent epithelization. This leads to faster regeneration and healing.

I watched Dr. Mortimer N. Hyams cone out several cervices with his raised wire electrodes and endothermy or radio frequency current and it surely does a nice piece of work. The hyperplastic endocervical tissue is coned out to the depth of about ⅛ inch and leaves a dry, easily-healing surface, with little danger of bleeding and almost no incapacity to the patient. It does not cut deep enough to interfere with dilation at subsequent labors as does the Strumdorf

Fig. I. Screw-tipped cautery.

conization, nor does it go deep enough to remove cysts. It is a much more complicated and expensive outfit than the nasal cautery and so can hardly be expected to be used by the general practitioner who is the only one who sees a great many cases of cervicitis. Fulguration with a diathermy is open to the same objection but in a lesser degree.

The new Ende-Cherry bipolar electrode does very nice work on the cervical canal itself, much like Hyams' endothermy method except that the slough is left in place. The disadvantage comes in not being able to fulgurate to the outer edge of a large erosion.

After cauterization the cervix is covered with a layer of soda bicarbonate one part and kaolin fifteen parts or some similar powder (12) applied with the powder blower. A 1 cm. hole is cut in the back of the bulb and closed with the thumb which acts as a valve so that the vagina may be ballooned more effectively. A rubber tube, one foot long, is inserted between the nozzle and the blower. For office treatments Wigmor's nozzle with the flange reversed is used, but when the blower is used by the patient at home as for contraception or treatment of the leukorrhea of gonorrhea or Trichomonas vaginalis vaginitis then the vulva is held tightly around the original nozzle (Fig. 2). This powder mumifies the bacteria.

The patient is told to go home, go to bed and stay there the next day and to douche twice daily with warm soda and boric acid solution, 1 teaspoonful of each to the quart. She is given six capsules of codein, one-half grain (½ gr.), aspirin three grains (3 gr.) and phenacetin two grains (2 gr.), to take every 3 or 4 hours for the cramps and told to expect a foul-smelling discharge from the burn for two weeks.

In five to seven days the tough white

Fig. II. Simple powder blower.

slough is generally loosened so that it can be gently removed with uterine forceps. This stops the discharge considerably and any bleeding from the separation of the slough may be stopped by pressure with a cotton pledget or by touching with a strong solution of ferric chloride or ferric sulphate. The cervix is then painted with iodine, pyridium or mercurochrome and the vagina is powdered as after cautery. Unless this slough is removed, serum may accumulate in the uterus to the amount of 1½ ounces and cause considerable distress and possibly ascending infection.

At the end of three weeks if healing is not satisfactory a biopsy is taken again and the cervix is retouched, usually using a diathermy point. In six weeks healing should be complete and vague aches and malaise from absorption should be gone, and all symptoms should be relieved.

Trachelorrhaphy usually by Strumdorf method or some modication is advised:

(1) In cases that do not respond to cautery.
(2) Where deep lacerations exist.
(3) Where other pelvic operations are indicated.
(4) In very sensitive individuals.
(5) In those with a very long portio which needs amputation. (11)

Associated parametritis, salpingitis, ureteritis, even if quiescent, contraindicate any local treatment to the cervix.

In Table 4 the results from the treatments were evaluated "good" when the lesion healed and the symptoms were relieved; "fair" when further treatment was necessary and symptoms persisted, and "poor" when the treatment failed to relieve or heal. Nothing but cautery gave very good results. The screw cautery gave promising results in the few cases where it was used. Surgical diathermy was used sooner or later in one-half of the cases, but did not show quite the efficiency (60% of good results) that the nasal cautery did (74%).

Table 4. Treatment and Results:

	Good	*Fair*	*Poor*	*No. Cases*
Mercurochrome 20%	—	—	4	4
Silver Nitrate 75%	1	2	6	9
Nitric Acid (fuming)	1	4	5	10
Chromic Acid	1	2	7	10
Galvanic Ionization	—	1	—	1
Hot Forceps	1	—	—	1
Dilation and Curettage	1	1	—	2
Trachelorrhaplasty	2	1	—	3
Screw Cautery	3	2	1	6
Diathermy (surgical)	15	7	3	25
Nasal Cautery	14	4	1	19

CONCLUSION

Cervicitis is a very common and much neglected disease and should be treated to prevent the development of cancer as well as to relieve distress.

It is caused chiefly by mixed infection following childbirth injury. Gonorrhea produces many cases. It is often associated with other birth injuries especially laceration and retroversion. If untreated it sometimes undergoes cystic degeneration.

The most prominent symptoms are leukorrhea and backache.

Treatment consists of removal of the hyperplastic endocervical tissue either with a scalpel or some cautery. The hot wire cautery is the most efficient and simple, but surgical diathermy is very good if handled correctly.

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Bilateral Congenital Hydronephrosis and Hydro-Ureteral Angularity; With Report of Two Cases Occurring in Sisters*

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In the present methods of operative and non-operative treatment of hydronephrosis and hydro-ureters, conservatism is the keynote by which we as urologists are governed. In all urology there is probably no condition which requires as much judgment, patience and time consuming study as this entity, particularly if it is bilateral.

The present conception of the pathological changes taking place in the kidney in hydronephrosis, as studied and established by Hinman in his most thorough manner, has given us a rather well understood method of handling the unilateral case. According to him the type of treatment is dependent upon repeated functional studies of both kidneys to determine the degree of hydronephrotic atrophy present in the affected organ and the percentage of function taken over by the unaffected side. This phenomenon he so well termed renal counterbalance. Attempted repair of unilateral infected hydronephrosis is unjustifiable, according to him, if fifty per cent of the function of the organ is no longer present. He concludes that this fact explains the all too frequent necessity of nephrectomy subsequent to plastic operations of all types on strictly unilateral hydronephrosis, and considers primary nephrectomy to be the treatment of choice, except in rare cases of marked degree where the compensatory function of the opposite kidney has been inhibited. Failure of compensation to take place may be due to inhibition of growth, disease or the lack of sufficient time for development. This compensation is accomplished by an hypertrophy of secretory units and requires a gradual and continuous stimulation.

Stutzin considers an attempted repair of unilateral hydronephrosis may be considered even in the presence of infection, but states that a subsequent nephrectomy may be necessary. Miller believes the treatment should be based primarily on the etiology, together with repeated pelvic lavages and states that in his experience conservative plastic operations on unilateral cases are rarely successful. Papin in 1928 outlined his treatment of these cases consisting of nephrostomy, pelvic resection and kidney fixation, but according to his report, subsequent nephrectomy was necessary in many of the cases. Quinby, however, believes that even if a kidney is not entirely satisfactory as regards functional capacity, it should be conserved, provided it is not grossly infected enough to be a threat or an actual hindrance to the normal life of the patient. In his opinion entirely too many nephrectomies have been performed on cases of unilateral hydronephrosis. He considers that if conservative plastic operations can be performed, considerable function will return, although it will not approach normal, and in this way many of these kidneys may be saved.

In this work, however, we are concerned mainly with the bilateral type of hydronephrosis where the ureter is involved on both sides, a condition frequently seen by all urologists. The causes of this condition are many and varied and very frequently not thoroughly enough ascertained before these unfortunate patients are relegated to chronic invalidism and untimely death by the fact that they are summarily dismissed as suffering from "congenitally anomalous ureters and kidneys." A considerable number of these cases have been reported where no anatomic or pathologic cause could be determined even at autopsy. Provided the thoroughness of the necropsy is beyond doubt,

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these cases may truly be called congenital. MacMynn states that gross removal of the entire urinary tract and a painstaking dissection is necessary before the obstructing factor is found, particularly if it is in the posterior urethra or in the bladder neck. Kessler reports one case where no anatomic obstruction could be found and concludes that it was one of congenital atonic development. Similar cases have been recently reported by Poynton, Miller, von Bunau, Ulrich, Massaglia, Hahn, Wolotski and Braasch.

Massaglia's case occurred in a new-born child whose mother suffered from hydramnios and he considered that condition to be the cause of the hydronephrosis through obstruction of the out-flow of the fetus' urine into the amniotic cavity. Von Bunau, upon microscopic study, found an abnormal proliferation of ureter cells and believes that the fluid in these large sacs is a secretion from hypertrophic ureteral mucosa, rather than from the kidney itself. Hahn and Wolotski attribute the cause to microscopic folds and plications in the ureteral wall. Braasch and Miller have found an atony of the ureter muscle layers, and Braasch states that localized areas of atony and cicatrical obstruction are coexistent in the same ureter. Mertz in 1930 reported a series of thirty-nine cases of spinal fusion anomalies—of which eleven cases showed urinary reflux with markedly dilated ureters and kidney pelves. These are true examples of the paralytic type.

ATTRIBUTED CAUSES

The attributed causes of these bilateral conditions are manifold and varied in their nature, depending upon the pathologic or anomalous conditions present in any given case under discussion. Some of these have been mentioned above. Young reported two cases in 1924 which came to autopsy and were found to be secondary to compression of the ureters by the uterine vessels in cases of uterine prolapse. The ureters below the point of crossing were unaffected. Miller states that the disturbance of ureteral peristalsis may be due to a primary atony, while Spitzer believes this atony to be secondary to fibrotic changes in the muscular layers of the ureter as a result of the effect of long-standing focal infections. Many writers, including Miller and Hahn, believe many of these conditions are due to an anomaly of ureteral innervation.

Many writers believe that some form of obstruction is the predominating factor in the etiology of this condition. MacMynn concludes that a definite obstruction can usually be found if carefully searched for. Vozza reports an interesting case in a still-born infant with urethral atresia in which the pyelorenal collections were of sufficient amount to cause dystocia during parturition.

Hinman states the causes of this condition are congenital only; while the effects are acquired, and the former may be very complex and often impossible to recognize. The most common congenital causes of hydronephroses are anomalies of the posterior urethra and bladder neck, anomalies of division and termination of the ureter and anomalies of vascularization of the upper tract. By this logic one may say that hydro-ureteral angularity is usually secondary and not primary, both congenital and acquired. The distinction of this pathologic entity lies in the twists and corkscrew deformities as a result of the over activity of the ureteral musculature, together with the always accompanying hydronephrosis.

The removal of the more injured of a pair of hydronephrotic kidneys is no longer considered to be in keeping with the conservative methods of renal surgery. Walther considers periodic pelvic lavage and drainage with the inlying ureter catheter as being adequate treatment for the average case and states that nephrectomy is rarely necessary.

In summing up his work on bilateral hydronephrosis and hydro-ureteral angularity Hinman stresses the importance of conserving renal tissue. The stimulation of either kidney to establish renal counterbalance is at the optimum (both sides being involved) resulting in a degree of reparative effort on the part of the renal units not seen in strictly

unilateral cases. Each case must of necessity be a case unto itself. Careful study extending over a considerable period of time is needed to ascertain the cause or primary obstructing factor, the degree of damage on one side as compared with the other, the amount of improvement and the ability of functionally returning toward the normal, as well as the controlling of infection by means of the inlying ureter catheter. Not one but many examinations and functional studies are necessary before this data can be accumulated and before determining the necessity of or the type of surgical intervention. A surprising number of cases will be found which will need no surgical procedures.

Provided conservative methods prove to be insufficient, I believe direct drainage, usually of the more involved side, by means of a nephrostomy tube, is a too much neglected procedure which is the first step in the plastic repair of these conditions. These hydrangular ureters are obstructive in themselves and the removal of the primary obstructing factor will not be sufficient to reestablish adequate ureteral drainage. It is therefore advantageous to free, as far as possible, all kinks of their adhesions, and to maintain as dependent drainage as possible by means of nephropexy.

The degree of functional improvement and the improvement in the general condition of the patient is our guide to the optimum time to pursue the next step. The lower ureter is freed in a manner similar to that of the upper end and the redundant portion resected. Re-implantation into the bladder completes the operation. At the time of the second stage of the procedure any obstructing factor in the lower urinary tract, such as prostate, prostatic bar or urethral valves, may be eradicated if present.

The degree of functional and general improvement in these cases is always surprising; and while these procedures are usually not permanently curative measures, a comfortable existence is afforded these unfortunate individuals and a premature demise from renal insufficiency and infection is averted.

Two cases of this condition, probably acquired from similar causes are presented. These cases are of additional interest, due to the fact that the patients are sisters of an identical age group. The first case was successfully managed in a strictly conservative manner; while the second was given the benefit of conservative plastic repair.

CASE I

The first case presented is that of a farmer's wife, age 29. Gave a history of pain in right lower quadrant 2½ years. Two children living and well.

Gall bladder and appendix out seven months previously. Her family physician had treated her for chronic endocervicitis three weeks prior to onset of present illness. Following this the patient had chills and fever and a return of the right lower quadrant pain much more severe than any she had had previously. This was accompanied by burning, frequency and nocturia. Estimated weight loss 11 lbs.

Examination:

Patient a visceroptotic female. Weight about 101 lbs.

Temperature 102.4 degrees. Apparently suffering from toxemia.

Urine packed with pus and clumps with many R.B.C.'s.

Colon bacillus on culture.

Cystoscopic:

Normal but delayed function from both sides.

Bilateral pyelograms show dilatation of both major and minor calyces. The terminal irregularities of the minor calyces are not effaced. Both ureters are dilated and tortuous with kinks and augulations. The degree of pelvic dilatation is not commensurate with that found in the ureters.

Diagnosis:

Bilateral hydronephrosis and hydro-ureteral angularity, obstructive type.

Treatment:

The patient had repeated pelvic lavages with the inlying ureter catheter on ten occasions from May 31 through July 12.

At this time: Bladder urine 1–3 pus cells. No clumps, no R.B.C.'s. Culture negative.

Patient's weight 109 lbs.

Nose, throat and dental foci eradicated and the cervix was cauterized.

Following this the patient had monthly checkups.

On April 2, 1930, the bladder urine showed only an occasional pus cell. Culture was negative. Patient's weight was 122 lbs. She had no pain and was able to do her usual work. In a recent communication the patient stated that she was free from all symptoms and had maintained her weight level.

CASE II

The second case is that of a woman 27 yrs. of age.

Three children living and well.

Stated that her sister has "kidney trouble."

Gall bladder and appendix removed in March, 1929.

Pus in urine has been present 4½ years, since her first pregnancy.

Pain in right lower quadrant for four years.

Frequency, burning and nocturia present one month.

Has lost some weight and has vaginal discharge.

Examination:

General physical examination negative. Patient is of the visceroptotic type.

Laboratory—Urine packed with pus and clumps, 2–3 R.B.C.'s per H.P.F.

Cystoscopy:

March 17, 1930. Large amount flocculent precipitate of debris in the bladder base. The ureteral meatus on the left was gaping and there was a to and fro movement of fluid through this with each respiratory movement. Indigo carmine returned in faint concentration in 4½ min. from the right side. No dye was seen to return from the left side in 15 min. Bilateral pyelograms on several examinations showed bilateral hydronephrosis with marked dilatation of the major calyces, tortuosity and angularity of both ureters. The middle third of right ureter was obstructed. In an attempt to control this patient's infection and to improve the kidney function, the kidney pelves were lavaged on five occasions.

On April 4, the patient returned home for three weeks. On her return she stated that she had been comparatively free from her right-sided pain and that her bladder "felt better." However, she had gained no weight.

Patient's nose, throat and dental foci were eradicated and the cervix was cauterized.

On July 8, the patient again returned complaining of severe pain in *left* lower quadrant.

The kidney pelves were successively lavaged on three occasions. The patient returned home at her request on July 17. She returned, however, on September 2, complaining of a return of severe left lower quadrant pain, and she stated that she was willing to under-go any form of treatment from which she could obtain relief. Her weight at this time was 98 lbs. She was advised to have a preliminary nephrostomy with freeing of the upper left ureter and nephropexy. This was performed September 6, 1930, under spinal anesthesia. A # 12 multiple eyed, soft rubber catheter was inserted through the renal cortex 2/3 distance to the bladder. Care was taken to make sure that some of the openings were within the kidney pelves. Her left-sided pain disappeared. The second stage operation (Hinman) was performed on September 22, 1930, under spinal anesthesia. Through a midline supra-pubic incision the bladder was opened. A right angled forceps was inserted through the dilated left ureteral meatus. The lower left ureter was freed and isolated up to the pelvic brim and amputated at the ureteral vesical junction. The free end of the ureter was drawn gently through the ureteral meatus into the bladder. The ureter was sutured to the external coat of the bladder in two layers; 8 cm. of redundant ureter was then resected intra-vesically. A large ureter catheter was introduced into the ureter and brought through the supra-pubic wound. Supra-pubic bladder drainage was instituted by means of a dePezzar catheter.

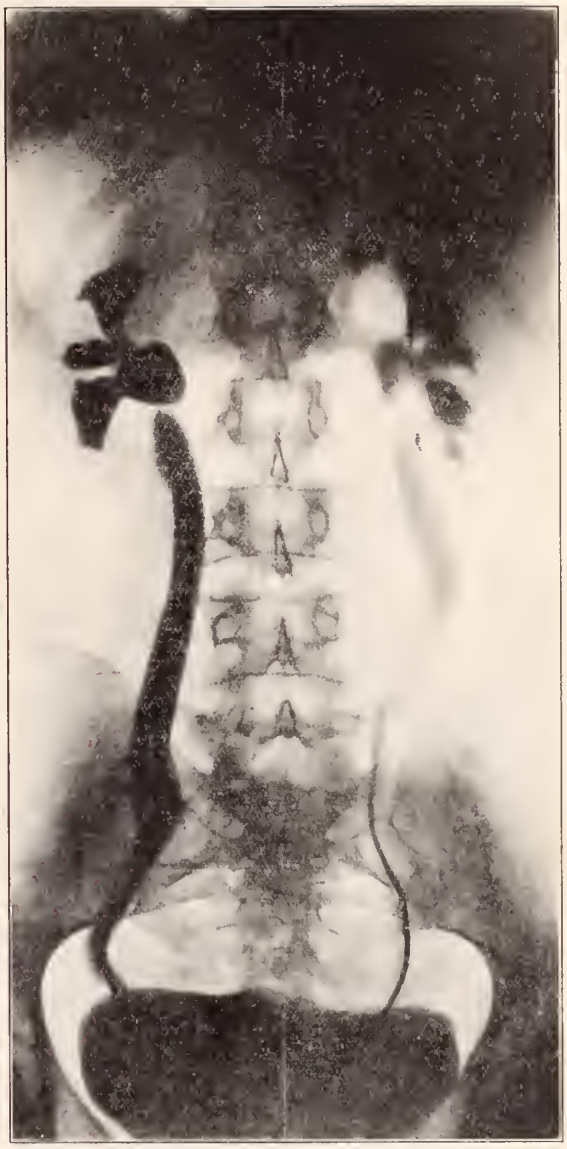

Fig. I. Composite pyelo-ureterogram showing dilatation of both major and minor calyces. The ureters are dilated and tortuous throughout. The degree of pelvic dilatation is not commensurate with that of the ureters and calyces.

The patient was discharged 24 days after operation.

On November 25, 1930, the patient returned for a follow-up examination. At this time her weight was 122 lbs. and she stated she had not felt better for several years.

Fig. II. Pyelo-ureterogram of left showing similar condition as in Figure III. The obstructing angulation and dilated portion of the lower ureter are clearly seen.

Fig. III. Pyelo-ureterogram of right kidney showing calyx and ureteral dilatation throughout. Note comparatively small kidney pelvis.

Urinalysis showed occasional pus cell present. No R.B.C.'s.

Cystoscopy performed November 25, 1930. No debris in the bladder base. On the left side the ureteral meatus was drawn laterally and posteriorly and was surrounded by several tags of redundant tissue. Large spurts of clear urine were seen to issue from this meatus. Indigo carmine returned from the left side in 5½ min., in 3 min. from the right side.

Pyelo-ureterogram showed the left kidney pelvis to be larger than on the previous examination. The ureter was dilated throughout but did not show all of the angulation seen on the pre-operative pyelogram. This is most noticeable in the lower ureter and shows the result of the plastic operation.

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Fig. IV. Shows obstruction and tortuosity and dilatation of left lower ureter.

Fig. V. Post-operative pyelo-ureterogram of the left side showing increased dilatation of the renal pelvis. The result of the plastic operation on the left lower ureter is clearly shown.

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Lipiodol as an Aid in Diagnosis and Guide in the Treatment of Antrum Disease

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The paranasal sinuses situated as they are in points inaccessible to direct inspection, made it imperative to search for means to render them more approachable, even though only inferentially. Transillumination, lavage, x-ray, along with the history and clinical findings, were the means relied on for a diagnosis. It was, however, soon discovered that they did not constitute proof sufficient in many instances. Not even the subjective location of pain offered positive evidence as to the locus of the pathology.

Mithoefer[1] found that the absence of suppuration in the antrum was compatible with hyperplasias and polyp formation. Lavage in such case would be essentially negative. Even the x-ray plates may be negative. Hirsch[2] explains this absence of objective evidence on the basis of the pathologic anatomy present. In catarrhal conditions including polyps, and he thinks that polyps are essentially nothing but catarrhal mucosa, the pathology is entirely intra-mucosal. It is a hydrops of the entire mucous membrane, the swelling reaching many times its normal thickness. There is no suppuration, and for that reason no pussy discharge. There may not even be any serum oozing through into the sinus cavity. Hence, negative washings. Transillumination is no more regarded, generally, as a means of diagnosis, and Israel[3] makes specific complaint against it.

As to the x-ray: Johnson[4] in a series of 300 cases found that in 35.3% of those which showed definite shadows on the film had no pus on washing; while 25.3% of the negative x-ray plates showed pus on washing. Mithoefer (Ibid) found marked hyperplasia of the antral mucosa with negative x-ray findings. Anderson[5] thinks that this confusion is due to the fact the shadows cast by pathologic processes can be confused so easily with normal anatomic variations in bony configuration and density. Johnson[4] gives seven reasons in explanation of this discrepancy between the x-ray and operative findings.

1. The angle of exposure. Any variation of the position of the head or the central ray will lead to quite a difference of the morphology on the film.
2. The age of the patient. The sinuses are underdeveloped in the young.
3. Sex. The male, as a rule, has denser bones.
4. Natural asymmetry.
5. Previous operations. Normal anatomy does not exist in the ethmoid capsule after an operation there.
6. Tumors in and around the sinus.
7. Foreign bodies in and around the sinus.

As a result of such experiences it was long felt that more than the hitherto known aids was necessary if better and more reliable diagnoses are to be made. As early as 1903, Weil[6] introduced radiopaque substance into the antrum of Highmore for diagnostic purposes. He used aqueous solutions of lead sulphate, and found them very helpful, especially in cystic conditions. Beck and Ramdohr[7] used bismuth paste but found it unreliable in that it could not be expected to fill out all the crevices. Potassium iodide and bismuth were employed by Brunetti and Philippini[8]. However, all these chemicals, either because of their physical properties, viscosity and osmotic pressure, or chemical nature, such as irritability to contiguous tissues had to be discarded. A substance that would be fluid enough to fill in the smallest kind of pocket, radiopaque, and inert to the tissues, as well as inabsorbable, was looked for. In lipiodol such a substance was found.

LIPIODOL

To Forestier and Siccard[9] we owe for the introduction of lipiodol into general radiologic practice. Forestier followed the matter up further and used it to trace fistulous tracts; he employed it in lung and bronchial

conditions; he injected into the epidural and arachnoid spaces of the cord for the purpose of studying the vertebrae of the region. Into the practice of rhinology lipiodol was introduced by Averchon and Worms[10]. Their studies which were done on the maxillary sinus chiefly warranted the assertion that lipiodol was indispensable in the practice of rhinology. They found that it not only helped in the understanding of the degree of the pathology but of the nature of it as well. They emphasized the fact that their choice of therapy, whether conservative or radical, in many cases depended on the lipiodol picture. Further extension of this substance in the study of the other paranasal sinuses in this country was enhanced by the improvement and discovery of new technic by Proetz,[11,12,13] and by Fraser.[14,15] Further study of sinus disease aided by lipiodol brought forward the fact that sinuses have a normal emptying time which may be altered in disease. Without the lipiodol this knowledge was not possible. It was long known (Hirsch, Ibid) that while the antrum lumen is decreased in the acute catarrhal stage, it may be increased in the chronic condition. The mucosa and the bone beneath it eventually undergo absorption, so that the walls of the antrum may be no thicker or denser than tissue paper. Lipiodol will differentiate such an antrum by bringing its outline into sharp relief.

Fig. A. This and Fig. B show how a normal sinus looks when filled with lipiodol. Fig. A is taken in Waters' position.

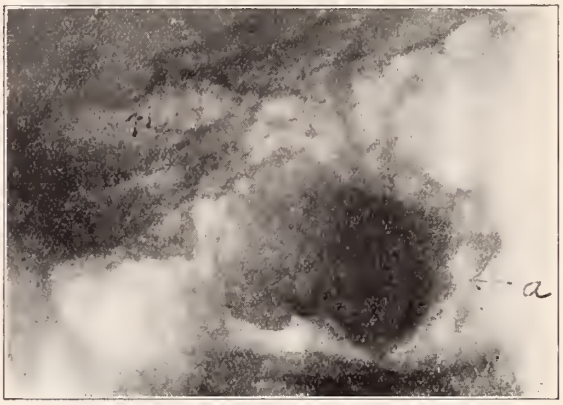


Fig. B. This is taken in the bitemporal position. Note the smooth and even outline of the mucous membrane lining the antrum.

TECHNIC OF INJECTION

The technic of antrum injection with lipiodol is fairly easy. Lipiodol diluted with twice its volume of mineral oil is warmed, preferably in a water bath which helps the two oils to mix more thoroughly. About ten cc. of this is injected into the antrum either by means of a Pierce canula through the natural opening in the middle meatus, or with a trocar through the inferior meatus. The average antrum capacity is 14.75cc. (Schaeffer, '20) so that most antra should receive the ten cc. of the oil. If the antrum overflows after four or five cc. of oil is injected, then either there is an unusual small normal sinus or a pathologic narrowing. The x-ray will decide that. One must bear in mind, however, that the antrum will fill up only to the ostium, which is close to the roof of the sinus. Absolute filling is impossible, nor is it necessary to fill it absolutely. For any quantity of the fluid, gravitating as it does with each position of the head, will show on the plate the condition of the antral wall of that region. The series of plates will then tell the story of the entire antrum.

The taking of the pictures is more of a feat. It is absolutely essential to maintain one angle of direction of the ray in all cases for each of the positions of the head. The head should be kept at the same degree of inclination to the plate in each case for each position. For after all the picture has to be interpreted and that is done by comparing shadows of greater and lesser density of normal with pathological plates, and a variation in the technic will reduce the comparative value of the film.

The following four positions should be

Case 1, Fig. 1. Waters' position. There is a small triangular area within markedly thickened walls.

taken with the oil in the sinus, after the usual antero-posterior and Waters' exposures had been made.

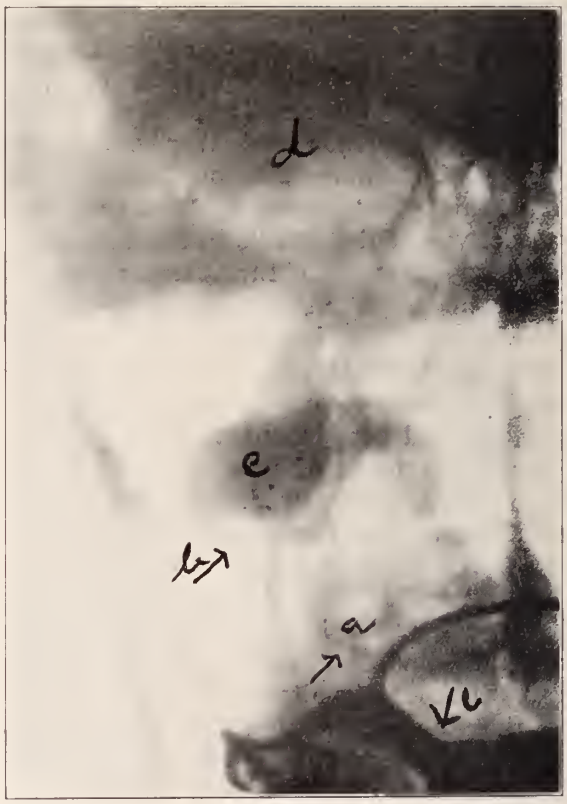
1. Antero-posterior.
2. Waters'.
3. Bitemporal, head resting on the ear of the side to be rayed.
4. Head tilted about 30 degrees toward the shoulder of the side to be rayed.

The exposure is the same as without lipiodol.

REPORT OF CASES

Mrs. S. H. 33 yrs. old complained of pain in the left face which radiated into the left side of the head persisting for several months. The pain was often severe enough to put her to bed in daytime and keep her from sleep at night. She was told that hers was a nervous headache from which there was no escape except what relief medicine would afford. Lately, she began feeling pain in the left eye, hence she wished to find out whether there was something wrong with it or with the glasses, being reconciled to the incurability of her pains.

Eye examination revealed no discernible acute pathology. Her astigmatism had been properly corrected for. The nose was essentially negative. Transillumination showed all of the sinuses on both sides denser than the average. The usual x-ray (Fig. 1) showed a thick antral wall (left) with a lighter triangular central area. Lavage via the inferior meatus was difficult and under pressure, but clear fluid returned. Air was forced through the trocar to blow all the water out and lipiodol was



Case 1, Fig. 2. Lipiodol. Note the unusually high antral floor (b) as compared to the nasal floor (a). The lighter band extending upward from a denser accumulation of the oil would indicate a partial filling of the sinus allowing only a film of the oil in that region. (c) bridge work. (d) orbit. (e) lipiodol mass.

injected and x-rayed at once. (Figs. 2 and 3) In comparison, Fig. 1 looks as of a different case. The absence of discharge on washing with this irregular filling of the lumen suggested the presence of either a neoplasm or polyps. At the operation a large inflammatory polyp was removed. The patient has been free from pain ever since. Just how a solitary polyp should cause so much of acute pain is a matter more of speculation along the way of Sluder's theory (Headache and Eye Disorder of Nasal Origin, '18) than of actual understanding. The fact however remains that with the polyp went the pain.

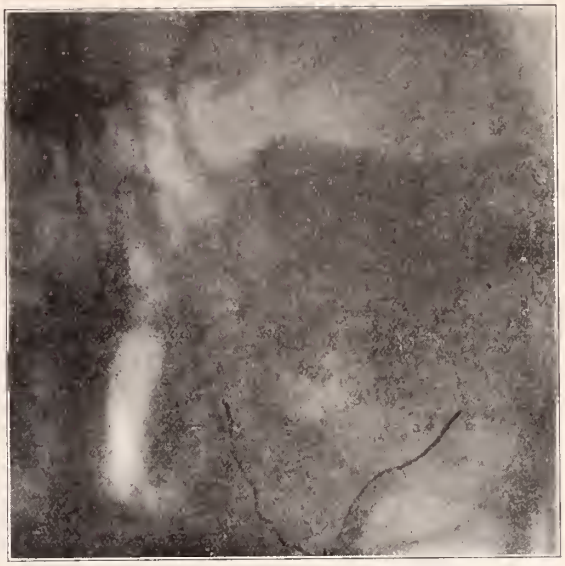
Miss R. S. 21 years old, bookkeeper, has had frequent colds for several years. Nasal breathing had nearly always been difficult. There were no sneezing spells of any unusual frequency or intensity. Three weeks prior to this consultation a severe cold put her to bed, with coughing, headache and fever. For the last week she was free from fever and for the last three days she was out of bed. She still has nasal discharge, inability to breathe through the nose and some vertex headache.

Examination showed both nares to be filled up with whitish glistening tissue bathed in mucopus. All of the sinuses were dark on transillumination.

Case 1. Fig. 3. Bitemporal position with the head tilted to the same shoulder. The filling defect of lipiodol (a) is so evident that comment is unnecessary.

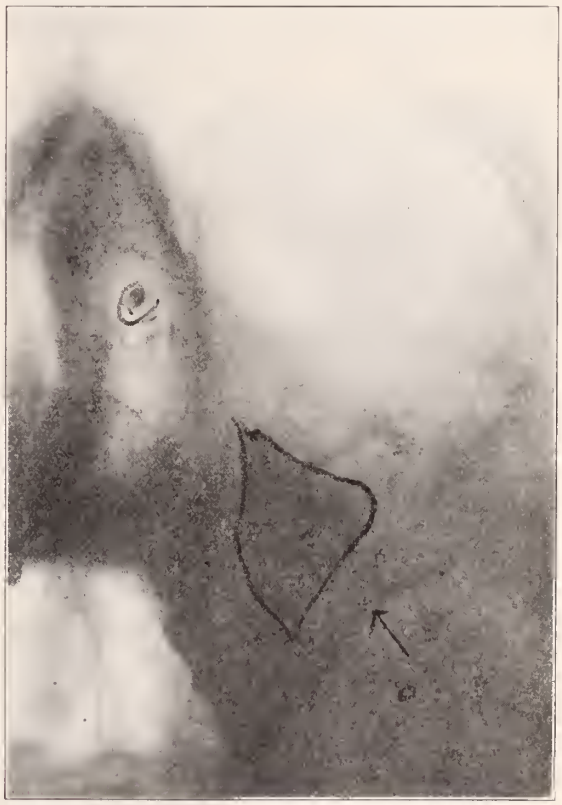
On removal, the polyposed tissue was found to be taking origin from the middle turbinates which were almost entirely degenerated. There was an "S" deviation of the septum with a prominent ridge to the left. Removal of this diseased tissue afforded enough breathing space, so that no submucous resection of the septum was necessary. The left inferior turbinate was of obstructive hypertrophy and was reduced by electrocautery. A week of daily cleansing followed by Downing packs began to restore to the nasal tissues their pink color. Nasal respiration was established, but the discharge from the right nostril continued strong, and the annoying vertex headache persisted.

X-ray without lipiodol was taken which showed the right antrum slightly denser than the left. (Fig. 1,(case 2.) Through the inferior meatus washing was attempted which was difficult and under high pressure, and which yielded about a dram of green pus. Iodol was injected through the same trocar in place and filmed again (Fig. 2). A definite filling defect is shown to exist in that sinus. Due to the difficulty of irrigation it was not persisted in for two weeks, when it was again attempted. It was now even harder to force the fluid through. However, a clump of greenish matter the size of a large pea came out. Lipiodol was again injected and x-rayed (Fig. 3). The filling defect has increased, the lumen



Case 2, Fig. 1. Ant. post. view, showing mainly the size of the antrum in non-iodolized plate.

is even more encroached upon. A closer study of the x-ray plate shows that while the walls of the sinus are thick, they are nevertheless of fairly uniform consistency and fairly smooth. In view of the



Case 2, Fig. 2. Bitemporal position. Very little lipiodol is retained showing the relative size of the antrum and that of the free lumen. (a) lipiodol, (b) the antral wall.

Case 2, Fig. 3 *(See inscription in next column.)*

Case 2, Fig. 4 *(See inscription in next column.)*

Case 2, Fig. 3. Two weeks later, note the further decrease in the size of the lumen. Bitemporal position with the head inclined toward the same shoulder.

Case 2, Fig. 4. One month later. Note the increased size of the lumen. Washing was easy at this time. (a) lipiodol in the sinus.

Case 2, Fig. 5. Compare this with Figs. "A" and "B." The sinus has filled out and a fairly uniform mucous membrane is shown. Anteroposterior view.

fact that there were no emergency symptoms referable to the antrum, i. e., no local pain, no fever, and no focal nerve symptoms, it was deemed well to watch things for a while. Hence nothing was further done to the sinus for a month, when the patient returned for an inspection. The antrum was now washed with ease, lipiodol films were made which showed a nearly normal filling. (Figs. 4 and 5, case 2.)

The mineral oil used as a diluent of the lipiodol obviated the possibility of an allergic reaction of the antral mucosa to the lipiodol, as suggested by Proetz.

CONCLUSION

Lipiodol is of unquestionable value for the understanding of the nature of the pathology as well as in the choice of therapy for any particular case of antral disease.

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Pneumonia Complicated by Empyema During Pregnancy; Report of Case

By EUGENE S. KNOX, M. D.
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On February 16, 1929, I was called to see a young woman, about twenty years of age, who was six and a half months pregnant at the time. She had become ill during the morning, complaining of weakness, headache, aching limbs and chest. She was placed in bed and treated symptomatically. The following day examination revealed a definite consolidation of the left lower lobe, temperature 104, respirations 22, pulse 120. The sputum was blood streaked. She was removed to the hospital at once where she pursued the typical course of lobar pneumonia. Her temperature remained about 103° for seven days and then dropped by crisis. Thereafter, it was normal.

I was very concerned during the whole illness about the effect of the pneumonia, with its accompanying toxemia, upon her pregnancy. Certain drugs and toxemias have a tendency to produce premature labor. The fetal heart sounds remained normal throughout, although they were somewhat faint.

On March 2, she was allowed to go home and during the succeeding days seemed to make favorable progress. On March 9, it was necessary to see her because of difficulty in breathing. Examination revealed an empyema on the left side. She was sent to the hospital again and on the following day a paracentesis was done. About 500 cc. of thin, greenish pus was removed, with marked relief of the disturbance in breathing. It seemed advisable to relieve her temporarily in this way rather than do a rib resection at once. Two days later on March 12, 1929, part of the seventh rib, just below the left scapula, was resected; considerable pus drained out and a double drain was inserted. She withstood the operation fairly well, although some cardiac stimulation was required. Her improvement following resection was gradual; drainage decreased and on April 14, 1929, she was allowed to go home.

On April 27, 1929, labor pains began, she returned to the hospital and gave birth to an eight months baby. Her delivery was perfectly normal and recovery was uneventful. The child was normal in every respect, except for being premature. The chest wound was still draining during her confinement; the drain was removed and drainage gradually ceased. Following her return home both she and the baby have done well.

(Continued on page 952)

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OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

EDITORIALS

A COSTLY MISTAKE

WE ARE evidently making a costly mistake in neglecting the subject of periodic health examinations.

Eight years ago, the American Medical Association began a campaign, through its publications and speakers, to educate the the public and physicians concerning the value of periodic examinations of apparently healthy individuals. Four years ago, our State Society made a determined effort to arouse interest in this state on the subject. The interest and response of the public has been so much greater than that of physicians that it has placed the medical profession in an unfavorable position.

Insurance companies have been successful in inducing their policy holders to take advantage of the check up examinations they offer them. Commercial organizations continue to prosper in the field of health examinations. Many so-called clinics have established a lucrative business and have extended their reputation over a large territory by paying particular attention to thorough physical and laboratory examinations. So much so, that "going through the clinic" has become a popular American pastime among those of our citizens who can afford to indulge in it. Our largest and most active health organization is inviting and urging everyone to come to its clinics for a free examination and is getting them to come, rich and poor alike.

In spite of all this, the general practitioner or family physician, who is the logical man to do this work, has neglected to take advantage of his opportunity. Too often, when an individual has approached his doctor on the subject he has been discouraged by being put off until a more opportune time or made to feel that it was all foolishness and that if he felt all right that he probably was all right. The council of the State Medical Society discontinued the appropriation for the office cards on health examinations this year because it felt that they were not used enough to justify the expenditure.

A discussion of the subject at a meeting of the county medical society will do much to clear up the matter, especially as to what the examination should include and in deciding upon a fair fee for the service in a given community. The blank supplied by the American Medical Association furnishes an excellent outline for this type of examination. A reasonable amount of thought and study on the part of the individual physician will fit him to do justice to this phase of his work. A sign in the waiting room and a few words here and there will let people know that he is ready and willing to take care of their requirements in this regard.

The new era in medicine demands that we spend a larger proportion of our time and effort in the prevention of illness and the discovery of disease in its earlier stages.

Can we afford to continue longer to ignore this worth while phase of medical practice? A. H. H.

EARLY DIAGNOSIS OF PREGNANCY

THE announcement elsewhere in this issue of the new laboratory service for the diagnosis of pregnancy marks another contribution which the Medical School of the University of Wisconsin has made to the profession of the state. Such procedures have been available for several years to clinicians working in the larger institutions where well equipped laboratories are provided. The extension of the advantages of the University's laboratories to the physicians of the state has come to be taken as a matter of course in Wisconsin. Nevertheless the prompt decision to make this important test available at cost is a matter for special attention.

It is perhaps unnecessary to dilate upon the situations in which this test may be of clinical significance. Medico-legal problems may require the earliest possible decision as to whether a pregnancy exists. It is now apparent that with this test a positive answer can be made to this question within four weeks after conception. In some patients obesity makes a diagnosis of pregnancy very difficult without such aids until the latter half of gestation. If intervention is indicated or if special medical care is required during a pregnancy it may be greatly to the advantage of both patient and physician to be sure of the pregnancy in the first two months. There are also numerous conditions with amenorrhea which mimic the gravid state. Not only the patient's peace of mind but the program of therapy to be followed will require the use of the most reliable and prompt methods for deciding the diagnosis. One of the difficulties of diagnosis in abdominal pain and with vaginal bleeding is the everpresent question of ectopic pregnancy. Since this can be diagnosed also by the new laboratory methods, it may become possible to decide upon emergency treatments with more positive information in such cases than has been available heretofore.

Another interesting aspect of this new service is the development of this laboratory and its methods out of research work in non-clinical fields. In this way the history of medicine is constantly being repeated, for out of investigations which seemed to be academic or without practical use have come many of the features which make modern medicine what it is. Medical men should not lose an opportunity to see that research work, even in "pure" science is supported.

MATERNITY—MORTALITY

THE high maternal mortality rate is made an occasion for frequent editorial comment. Also the high tuberculosis rate among young women of the childbearing age. Less often attention is called to the likelihood of a young woman being subjected to the double strain of tuberculosis *and* pregnancy. Both phthisiotherapists and obstetricians view the complication with dread and alarm.

Without minimizing the great risk, medical essayists of wide experience seem to be striking a more optimistic note than that which prevailed a few years back. Thus Jennings and Mariette of Minneapolis have recently suggested that with superlatively good sanatorium care during the puerperium and every possible provision to make labor as rapid and easy as possible, many a tuberculous woman can be successfully carried through her pregnancy. Furthermore, in many cases, her tuberculosis does not seem to be greatly aggravated thereby.

Inasmuch as pregnancy frequently discloses a hitherto unsuspected tuberculosis or converts an occult form into an active and malignant one, every family physician should be constantly on the lookout for tuberculosis among his pregnant patients. Finding it, he should be obdurate in his insistence on the best of sanatorium care and the strictest regimen during, and following, the childbearing period.—H. E. D.

THE PRESIDENT'S PAGE

IN THE PUBLIC INTEREST

AS PHYSICIANS, we are very interested in the legislation enacted by the last session of Congress, which provides hospitalization and a complete medical and surgical service to any and all disabled veterans of the World War, irrespective of the origin of their disability.

We are not opposed to, but favor the extension of these benefits to this group of men, but we are very interested in the method by which it shall be accomplished. Such service was heretofore afforded to veterans with service connected disability. These men were placed in veterans' hospitals and served by a staff of physicians who are employees of the Bureau. Thus we had a system of State medicine in which the patient could not choose his physician or hospital, and in which the payment was under a capitation rather than a fee system. We believe these features are not in the interest of the physician, civilian hospital, the general public, or the veteran himself.

It is manifestly unfair especially to the physician who served in the war, since it obliges him to pay by taxation for service which he is prepared to render and should be allowed to render. As a result both his income and practice are affected.

It is unfair to the present existent civilian hospitals built and equipped to take care of the people of the area in which they exist. It deprives them of a legitimate clientele, and since very few of such institutions are at present self-sustaining, it will further reduce their patronage and hence increase the cost of hospital care to the general public.

It will deprive a veteran of the right to choose his own hospital and his own physician, and we believe that he should be allowed to choose both. It will afford an unequally distributed service since many disabled veterans can not or will not avail themselves of it. There will be emergency cases that can not wait or be transported. There will be veterans who will not willingly leave home and family to go to distant government institutions, and there will be disabilities that do not need hospitalization but do need medical care.

The Shoulders resolution[1] suggests that in place of the method provided, the government or the Bureau should provide for the veteran health and accident insurance under which an adequate hospital benefit and a weekly indemnity, say of $20, be afforded. Then the service would be equally distributed, no injury would be done the civilian hospital, or the public, or the physician. An indemnity of $20 weekly would take care of usual medical and surgical fees and in many instances would leave a balance to be used for family maintenance.

Moreover, it is estimated by the Bureau itself and substantiated by figures of the incidence of morbidity of the great health insurance companies, that the substitute method would cost millions of dollars less annually and thus be a benefit to the tax payer while it gave greater and more equitable service to the soldier.

Physicians should study this law and the substitute proposed and be ready to enlighten their friends, the public, but especially the veteran, so that the latter may receive the greatest benefit from such law and be allowed to choose his hospital and his physician, which we think are essential to the best service.

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[1] See page 950.

THE STATE MEDICAL SOCIETY OF WISCONSIN

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LIST OF EXECUTIVE OFFICERS OF COUNTY MEDICAL SOCIETIES

County	President	Secretary
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Barron-Washburn-Sawyer-Burnett	J. H. Wallis, Rice Lake	E. R. Hering, Shell Lake.
Brown-Kewaunee	A. J. McCarey, Green Bay	E. S. Knox, Green Bay.
Calumet	A. C. Engel, New Holstein	A. F. Slaney, Hilbert.
Chippewa	F. T. McHugh, Chippewa Falls	J. A. Kelly, Chippewa Falls.
Clark	R. R. Rath, Granton	A. L. Schemmer, Colby.
Columbia	A. J. Batty, Portage	H. E. Gillette, Pardeeville.
Crawford	A. J. McDowell, Soldiers Grove	C. A. Armstrong, Prairie du Chien.
Dane	F. F. Bowman, Madison	L. V. Littig, Madison.
Dodge	E. P. Webb, Beaver Dam	A. W. Hammond, Beaver Dam.
Door	John Hirschboeck, Forestville	
Douglas	J. W. McGill, Superior	C. H. Christiansen, Superior.
Eau Claire and Associated Counties	E. E. Tupper, Eau Claire	P. G. Spelbring, Eau Claire.
Fond du Lac	H. A. Devine, Fond du Lac	H. R. Sharpe, Fond du Lac.
Grant	E. A. A. Dunn, Platteville	M. B. Glasier, Bloomington.
Green	W. B. Gnagi, Sr., Monroe	J. F. Mauermann, Monroe.
Green Lake-Waushara-Adams	J. M. Johnson, Ripon	A. J. Wiesender, Berlin.
Iowa	T. A. Hagerup, Dodgeville	H. M. Walker, Dodgeville.
Jefferson	Will Young, Ft. Atkinson	M. G. Peterson, Lake Mills.
Juneau	C. A. Vogel, Elroy	A. T. Gregory, Mauston.
Kenosha	W. H. Bennett, Kenosha	W. H. Lipman, Kenosha.
La Crosse	W. J. Jones, La Crosse	R. L. Eagan, La Crosse.
Lafayette	R. B. Quinn, Darlington	W. B. Williams, Argyle.
Langlade	E. J. Donohue, Antigo	J. C. Wright, Antigo.
Lincoln	F. L. Kelley, Merrill	W. H. Bayer, Merrill.
Manitowoc	W. G. Kemper, Manitowoc	C. H. Barnstein, Newton.
Marathon	Joseph F. Smith, Wausau	Verne E. Eastman, Wausau.
Marinette-Florence	T. J. Redelings, Marinette	M. D. Bird, Marinette.
Milwaukee	E. L. Tharinger, Milwaukee	Theo. Wiprud, Ex. Sec'y, Milw.
Monroe	A. E. Winter, Tomah	H. H. Williams, Sparta.
Oconto	R. J. Goggins, Oconto Falls	G. W. Krahn, Oconto Falls.
Oneida-Forest-Vilas	C. D. Packard, Rhinelander	I. E. Schiek, Rhinelander.
Outagamie	J. L. Benton, Appleton	R. V. Landis, Appleton.
Pierce-St. Croix	H. P. Conway, Spring Valley	A. E. McMahon, Glenwood City.
Polk	L. O. Simenstad, Osceola	Geo. B. Larson, Frederic
Portage	F. A. Marrs, Stevens Point	H. P. Benn, Stevens Point.
Price-Taylor	F. W. Mitchell, Medford	G. E. MacKinnon, Prentice.
Racine	J. F. Bennett, Burlington	Susan Jones, Racine.
Richland	Bertha Reynolds, Lone Rock	G. Benson, Richland Center.
Rock	H. E. Burger, Beloit	E. C. Hartman, Janesville.
Sauk	Roger Cahoon, Baraboo	A. C. Edwards, Baraboo.
Shawano	C. E. Stubenvoll, Shawano	L. W. Peterson, Shawano.
Sheboygan	John Hansen, Glenbeulah	A. C. Radloff, Plymouth.
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Waukesha	F. J. Donnelly, North Lake	J. F. Wilkinson, Oconomowoc.
Waupaca	R. K. Irvine, Manawa	F. J. Pfeifer, New London
Winnebago	G. V. Lynch, Oshkosh	M. C. Haines, Oshkosh.
Wood	F. X. Pomainville, Wisconsin Rapids	W. G. Sexton, Marshfield.

SOCIETY PROCEEDINGS

BROWN–KEWAUNEE

The first regular meeting of the Brown–Kewaunee County Medical Society since the summer vacation was held on September 24th in Hotel Northland, Green Bay. Dinner was served and a scientific program followed.

The teaching staff of the department of corrective speech and deaf of the city schools of Green Bay attended the meeting and explained the method of handling cases of that type. Practical demonstrations were also given. A short business meeting followed the program.

DANE

The Dane County Medical Society met on October 7th.

Addresses were given by Mr. Alvin E. Gillett, secretary of the Madison Association of Commerce; Dr. George G. Stebbins, Madison, read a paper on the significance of injection in the treatment of internal hemorrhoids, and Dr. Francis Paul, Madison, told of the progress of European medicine. About sixty members attended.

KENOSHA

Dr. H. C. Schumm, Milwaukee, was the guest speaker at the regular monthly meeting of the Kenosha County Medical Society which was held at noon at the Elks Club, Kenosha, September 29th.

Dr. Schumm spoke on "Infantile Paralysis and Its Treatment" illustrated with slides, and was followed by a round table discussion of the disease.

A short business meeting preceded the talk.

MARINETTE–FLORENCE

The Marinette–Florence County Medical Society held its monthly meeting, Thursday evening, October 17th.

Dr. E. W. Exley of Green Bay presented a paper on "Differential Diagnosis and Treatment of Pyelonephritis" illustrated with slides.

A good attendance was present, and all had an enjoyable and profitable evening. M. D. B.

MILWAUKEE

At the first monthly meeting of the Medical Society of Milwaukee County since last spring, a most interesting program was given. Dr. Hugh W. Groves, vice-president and trust officer of the First Wisconsin Trust Company, Milwaukee, spoke on "Safe Investments", and Mr. Robert R. Aurner, professor of business administration, University of Wisconsin, addressed the members on "Putting Simple Business Methods Into The Doctor's Office." Both of these talks were most enthusiastically received by the attending members.

Following the program the meeting adjourned to the social hour. There were 150 members present.

T. W.

PIERCE–ST. CROIX

At a meeting of the Pierce–St. Croix County Medical Society, held in River Falls, October 22nd, the following officers were elected for 1932: President, Dr. H. P. Conway of Spring Valley; Vice-President, Dr. G. M. Dill of Prescott; Secretary-Treasurer, Dr. A. E. McMahon of Glenwood City; Censor (3 years), Dr. J. W. Livingstone of Hudson; Delegate, Dr. A. E. McMahon of Glenwood City; alternate, Dr. R. U. Cairns of River Falls. A. E. McM.

POLK

The Polk County Medical Society invited the members of the county medical societies located in the "Friendly Valley" district to attend a meeting devoted to the discussion of periodic health examinations. The societies included were: Barron, St. Croix, Washington, Chisago and Pine.

Dr. R. G. Leland, director of the bureau of medical economics, American Medical Association, gave a paper on "Modern Medicine." Dr. W. A. O'Brien, University Hospital, University of Minnesota, outlined the ideal system of periodic health examinations in effect at the University of Minnesota. Dr. C. B. Wright of Minneapolis gave a practical and helpful talk on methods of interesting patients in the subject of periodic health examinations and methods of selling the benefits of the annual health audit to the public. The most vital point was that of convincing the public that the profession is sincere by having the individual societies examine their own members and their families. Dr. Wright performed an examination before the group pointing out diagnostic aids as he examined the patient. G. L.

ROCK

A meeting of the Rock County Medical Society was held on September 29th at Hotel Hilton, Beloit.

Dr. H. E. Burger, president of the Rock County Medical Society, spoke on the advantages of caring for the poor in local hospitals. The Rock County Co-operative Medical Clinic, Inc., which has been organized to conduct the free county medical clinics is strictly for charitable purposes, Dr. Burger said. It will be operated on a systematized basis with practically all of the Rock county physicians as members.

Dr. Wayne A. Munn, president of the Rock County Co-operative Medical Clinic, urged the members of the Society to volunteer their services to the free clinic.

The Society appointed a committee to take under advisement the request of W. J. Dougan, who ap-

peared before the Society to request free examination of 4-H rural boys and girls club members. Dr. W. A. Munn, Janesville, and Drs. C. F. N. Schram and L. J. Friend, Beloit, were named to the committee.

Dr. Frank W. Mackoy of Sacred Heart Sanitarium, Milwaukee, gave an address, illustrated with slides.

Fifty physicians attended the six-thirty o'clock dinner which preceded the meeting.

WAUKESHA

Dr. Chester C. Schneider, Milwaukee, addressed the Waukesha County Medical Society at Draper Hall, Oconomowoc, Wednesday afternoon, October 7th, on the subject of "Fractures of the Hip." Each phase of the management of acute and chronic ununited fractures at the hip was discussed including conservative and operative treatment of acute fractures as well as various methods of rehabilitation and reconstruction in chronic cases. This talk was augmented with especially prepared charts, photographs, and blackboard drawings.

NINTH DISTRICT

The autumn meeting of the Ninth Councilor District Medical Society was held at the Hotel Wausau, Wausau, on the evening of September 30th. Dinner was served at the Hotel Wausau at 6:30 P. M., after which a very interesting address on "Medical, Social and Economic Conditions in Russia" illustrated by three reels of motion pictures was given by Dr. Tobias L. Birnberg of St. Paul, Minnesota.

Dr. Birnberg, during a tour of Russia in the summer of 1930, had an opportunity to visit a number of the larger cities and observed the developments which were going on in economic and social lines as well as in medical circles. While there have been undoubtedly some developments which appeared to be for the better of the people in general, he apparently seemed to feel that the general situation was still surrounded by a good deal of uncertainty and that in all probability a good many years would elapse before definite conclusions could be drawn as to the correctness of the theories upon which the government is operating.

A vote of thanks was extended to Dr. Birnberg for his excellent talk.

On motion, the Society adjourned to meet at Marshfield for the winter meeting. J. F. S.

TENTH DISTRICT

The 31st annual meeting of the Tenth District Medical Society was held at Eau Claire on September 24th. The morning program consisted of dry clinics held at Sacred Heart hospital and were conducted by the following:

Dr. Henry E. Michelson, Minneapolis, skin clinic.

Dr. James G. Carr, Chicago, medical clinic, heart cases.

Dr. Kellogg Speed, Chicago, surgical clinic, fractures and dislocations.

Following luncheon at the hospital, the afternoon program was presented as follows:

"Unhappy Results in Treatment of Fractures" by Dr. Kellogg Speed.

"Relationship of Pathologic Physiology to Symptoms and Diagnosis of Heart Disease" by Dr. James G. Carr.

"Skin Cancer" by Dr. Henry F. Michelson.

"Phrenecotomy" by Dr. Geo. W. Beebe.

A golf tournament and banquet at the Eau Claire Country Club concluded the meeting. About one hundred members attended.

CENTRAL WISCONSIN SOCIETY OF OPHTHALMOLOGY AND OTO-LARYNGOLOGY

The fall meeting of the Society was held at St. Joseph's Hospital, Marshfield, October 11th and 12th.

The program opened with a clinic at nine o'clock at the hospital and continued through the afternoon with a meeting at the Marshfield Clinic library. The afternoon speakers were:

Dr. J. F. Pratt, Minneapolis, whose subject was "Indications for Tonsillectomy."

Dr. W. M. Nesbit, Madison, spoke on "Intracranial Complications of Ear Infections."

Dr. Walter Camp, Minneapolis, discussed "Sympathetic Ophthalmia."

At six-thirty, dinner was served at the Charles Hotel and at eight o'clock the final sessions of the Society were held at the Clinic library. The following papers were read at the evening session:

"Melanotic Tumors of the Eye" by Dr. Walter Camp.

"Operative Points Which Make Intranasal Operations Successful" by Dr. F. J. Pratt.

Members of the Society were entertained on Sunday afternoon at golf at the Bull's Eye Country Club, Wisconsin Rapids. It was decided to hold the spring meeting at Green Bay, and next fall the Society will be entertained at Minneapolis by the Minnesota Academy of Ophthalmology and Oto-Laryngology.

Officers of the Society were re-elected as follows: Dr. J. J. Robb, Green Bay, president; Dr. W. J. Frawley, Appleton, vice-president, and Dr. L. A. Copps, Marshfield, secretary-treasurer.

MILWAUKEE ACADEMY OF MEDICINE

The monthly meeting of the Milwaukee Academy of Medicine was held Tuesday evening, October 13th. A council and business meeting preceded the scientific one at which the following program was given:

"Report of Some Cases of Duodenal Fistulae," by Dr. F. A. Stratton, Milwaukee.

"The Late Results Following Total and Sub-total Gastrectomy in Dogs," by Dr. A. C. Ivy, professor of physiology, Northwestern University.

The following resolution was passed at this meeting:

"WHEREAS, the death of one of our esteemed members, Dr. Lorenzo Boorse, has left a serious void in the ranks of the medical profession of our city; and

"WHEREAS, by his unselfish devotion to his work in the alleviation of suffering and the cure of disease, he has been a credit to his profession and has endeared himself to mankind; and

"WHEREAS, by his past presidency, long membership and untiring interest in the Academy of Medicine, he has achieved a place of high esteem of his fellow members; now, therefore, be it

"*Resolved*, that the Milwaukee Academy of Medicine go on record as expressing its deep regret at the death of Dr. Boorse and as extending to his bereaved family its deepest sympathy; and be it further

"*Resolved*, that this resolution be spread upon the minutes of the Academy and a copy be sent to Mrs. Boorse.

"(Signed) Robert W. Blumenthal, Geo. V. I. Brown, C. H. Stoddard."

MILWAUKEE PEDIATRIC

The Milwaukee Pediatric Society held its 30th meeting at the Milwaukee Children's Hospital, Wednesday evening, October 14th. The program was as follows:

Case Presentation "B. Coli Meningitis." Dr. H. O. McMahon.

"The Apple Diet in Diarrhea of Infants." Dr. T. L. Birnberg, St. Paul.

"The Present Status of Intraperitoneal Transfusion." Dr. J. Martin Sansby. (Thesis for admission to membership.)

Out of town guests in addition to Dr. Birnberg were Drs. Kent Tenney and J. E. Gonce, Jr., of Madison and W. C. Crawford of Rockford, Illinois. F. R. J.

MILWAUKEE HOSPITAL INTERNS

The Milwaukee Hospital Interns' Association held its first meeting of the year at the home of Dr. John McCabe. New officers were elected, as follows: Dr. Edwin Evert, President; Dr. Arthur Hanson, Vice-President; Dr. Harry Barnes, Secretary; Dr. Robert Wheelihan, Treasurer.

The next meeting of this Association was to have been held on October 14th, but has been postponed because of the monthly meeting of the Medical Society of Milwaukee County, which is to be held on that date.

NEWS ITEMS AND PERSONALS

Dr. Arthur W. Rogers, chairman of the Council of the State Medical Society, left on October 4th for the Canyon of the Colorado to be gone a little over two weeks.

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Dr. R. S. Hirsch, formerly of Lake Geneva, is now associated with the Ludden Clinic in Viroqua.

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Equipment valued at approximately $5,000 has recently been donated to the Beloit Municipal Hospital by an anonymous donor. The donated equipment which completes the facilities of the hospital was as follows: electrocardiograph, portable x-ray, electro magnet, oxygen tent, and ventilation doors.

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Dr. Francis Paul of Madison addressed a meeting of the American Business Club at Hotel Loraine, Madison, on October 5th. Dr. Paul spoke on "What's Wrong With Europe Today."

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Dr. A. J. Wagner, a graduate of Marquette University School of Medicine in 1931, in October became associated with Dr. P. J. Wollersheim of Forest Junction, Wisconsin.

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Dr. W. J. Frawley of Appleton is recovering from an operation for appendicitis.

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Plans for re-opening the old Brookside hospital at Boscobel have been formulated by a group of Boscobel citizens. Articles of incorporation have been filed as a non-stock and non-profit company. The hospital will have ten beds, and operating and x-ray equipment and it is expected to be ready in March, 1932.

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Dr. Alfred J. Roach, formerly of Ashland, left on October 8th for Albany, New York, to take up his duties with the New York State Department of Health as supervisor of Tuberculosis hospitals.

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Dr. Otho A. Fiedler, president of the State Medical Society, was speaker on the program for the laying of the cornerstone of the new Sheboygan Memorial hospital on Sunday, October 6th.

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Dr. Robert E. Burns of Wisconsin Orthopedic Hospital, Madison, spoke on "Infantile Paralysis" before the members of the Wisconsin Rehabilitation Institute who met in Madison for a three day session.

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Dr. Edger F. Andre, son of the late Dr. F. E. Andre of Kenosha, and a graduate of Marquette University School of Medicine in 1931, has opened offices at 5605 Sixth Avenue, Kenosha.

—△—

Dr. W. A. Deerhake, superintendent of the State Central Hospital for the Criminal Insane, Waupun, was elected commander of the Dan E. Getchell Post, American Legion.

Dr. and Mrs. Harry H. Heiden and Mr. and Mrs. Clayton Bond motored to Toronto, Canada, to attend the sixth annual conference of clinic managers held on September 24–25. Dr. Heiden is secretary of the Sheboygan Clinic, and Mr. Bond is the business manager. Mr. Bond was speaker on the program. After the conference they motored to Quebec, through the New England states, and to New York City.

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Dr. Francis J. Brennan, a 1931 graduate of Marquette University School of Medicine, has opened an office over Brennan's Drug Store, Oshkosh.

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Dr. W. T. Lindsay, Madison, gave a radio address on October 8th as president of the Madison Public Welfare Association.

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Dr. Gerald Shaw, who returned recently from a trip abroad, is now associated with his father, Dr. B. W. Shaw of Waunakee.

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Dr. Otho A. Fiedler, president of the State Medical Society, was one of the speakers on the program for the dedication of the new Wisconsin Orthopedic hospital at Madison on November 8th.

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Drs. V. F. Marshall and C. D. Neidhold, Appleton, have moved into their new clinic on the fifth floor of the Irving Zuelke building.

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Dr. R. C. Buerki, superintendent of Wisconsin General Hospital, was a speaker before the American Hospital Association's annual meeting at Toronto, Canada, during the week of September 28th.

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Dr. E. L. Tharinger, and Mr. Theodore Wiprud, president and executive secretary, respectively, of the Medical Society of Milwaukee County, and Dr. Leland M. Cox, Chicago, visited the offices of the State Medical Society in October.

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Dr. F. F. Bowman, city health officer for Madison, attended the convention of the American Public Health Association held in Montreal, Canada, in September.

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Dr. F. A. Birnbaum, Marathon, is recovering from an illness.

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Dr. F. E. Chandler, mayor of Waupaca, and Mrs. Chandler returned in October from a six weeks' trip to Alaska which included a trip up the Yukon River.

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Dr. P. L. Heitmeyer, Appleton, is taking a two years' course in the Graduate School of Medicine, University of Pennsylvania.

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Dr. R. C. Buerki, Madison, was speaker at a meeting of the Kiwanis Club at Hotel Chilton, Chilton.

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Dr. Philip Desbois, formerly of Peshtigo, Wisconsin, has moved to 548 Main Street, Oconto.

Dr. G. W. Henika, assistant state health officer, Madison, spoke before a meeting of the Emerson Pre-school and Kindergarten Mothers Club on the subject of infantile paralysis.

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Dr. Gunnar Gundersen, La Crosse, visited the offices of the State Society, Madison, on October 16th.

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Dr. A. J. McCarey of Green Bay has returned from New York where he attended the Clinical Congress of the American College of Surgeons. While in the east he visited his daughter who is attending school at Mount Vernon Seminary, Washington, D. C.

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Dr. R. P. Potter of Marshfield attended a joint meeting of the Iowa X-Ray Club, the Radiological Section of the State Medical Society, and the Minnesota Radiological Society held at the Mayo Clinic, Rochester, in October.

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Dr. Homer Carter, Madison, attended a meeting of the Central States Pediatric Society in Cincinnati, Ohio.

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Dr. W. W. Bauer, Racine, addressed a meeting of the young people's department of the First Baptist Church.

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Four Wisconsin physicians will be among those who will address the meeting of the Radiological Society of North America, to be held on November 30th in St. Louis. They are: Dr. J. J. Eisenberg, Dr. H. B. Podlasky, vice-president of the Society, Dr. Norbert Enzer, all of Milwaukee, and Dr. E. A. Pohle, professor of radiology, University of Wisconsin, Madison.

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Dr. F. J. Pfeifer of New London with a party of hunters enjoyed a week's hunting trip in North Dakota the latter part of October.

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Dr. W. A. Rauch has resumed his practice at Valders after having completed a four weeks' postgraduate course in piediatrics at Barnes Hospital and St. Louis Children's Hospital at St. Louis, Mo.

EDUCATION OFFERED DEAF CHILD

Unusual educational opportunity for a young deaf child is offered in a nursery school allied with a college of recognized standing, child must be about two years of age, of good heredity and of bright mentality. Educational activities of the child will be under the supervision of a specialist in the education of the deaf. For further particulars, address: H. G. S., Care of Wisconsin Medical Journal.

Dr. J. E. Meany of Manitowoc has accepted the position of city physician of Manitowoc.

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MILWAUKEE

Dr. and Mrs. Otto H. Foerster have returned to the city after spending the summer at their country home at Fox Point.

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Dr. and Mrs. Otto H. Foerster have returned from the East where they motored with their son, who is resuming his studies at Haverford College, Haverford, Pennsylvania.

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Dr. W. J. Carson was the speaker at a recent meeting of the Professional Men's Club. His subject was "Science and Conscience in Surgery."

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Word has been received in Milwaukee of the death of Dr. Peter Jobse at his home in Wilsonville, Oregon. Dr. Jobse was born in Milwaukee, and after receiving his medical training at what is now the Northwestern University Medical School returned to Milwaukee where he practiced medicine for a great number of years. Dr. Jobse was 62 years of age. He is survived by his wife, Mrs. Mary Fitzgibbon Jobse, a brother, Dr. William Jobse, and three sisters, all of Milwaukee.

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Dr. Harry W. Sargeant, superintendent of the Milwaukee County Hospital, and Mr. William L. Coffey, manager of the Milwaukee County Institutions, attended the American Hospital Association Convention in Toronto, Ont., the first week in October.

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Dr. Nelson M. Black, who has been visiting Dr. and Mrs. Otto H. Foerster, has returned to his home in Miami, Florida.

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Dr. A. A. Pleyte, a staff member of the Wisconsin Anti-Tuberculosis Association, was elected secretary of Mississippi Valley Sanatorium Association in St. Paul, where sessions of the conference on tuberculosis were held the latter part of September. Dr. Pleyte has long been considered an authority on the prevention of tuberculosis.

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Dr. and Mrs. John P. Koehler recently returned from a ten-day trip to Montreal and Quebec.

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Dr. and Mrs. J. E. Habbe have returned from a vacation spent in Atlantic City.

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Dr. and Mrs. E. L. Schreiber celebrated their silver wedding anniversary on October 3rd.

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Dr. William L. Herner recently attended a medical convention in New York City.

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Dr. and Mrs. H. A. Sifton have returned to their home in Milwaukee after having spent the past four months at their summer home at Sister Bay.

Dr. and Mrs. Harold E. Holbrook recently enjoyed a short vacation at Brule, Wisconsin.

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In cooperation with the University of Wisconsin Extension Division the Society is again offering a course in public speaking. There will be two classes if the enrollment is enough to warrant them,—one an elementary class and the other an advanced group. Professor H. L. Ewbank of the Department of Speech, University of Wisconsin, has consented to return to Milwaukee to conduct the classes as he did before. Professor Ewbank is very popular with members of the medical profession in Milwaukee.

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October 27th has been designated as Navy Day. An invitation has been extended by the U. S. Naval Hospital, Great Lakes, Illinois, to the medical profession of Milwaukee County to visit the institution on that day. There will be a buffet luncheon between 1:30 and 3 P. M., at which time informal talks will be made. There will be no stated clinical demonstrations, but physicians will be welcome to visit and see what they are particularly interested in.

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The diagnostic clinic of the Evangelical Deaconess Hospital closed on September 1st.

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Mr. E. H. Bartelsmeyer, executive secretary of the St. Louis Medical Society, visited at the executive office of the Medical Society of Milwaukee County on September 25th. Mr. Bartelsmeyer, who represents one of the largest county medical societies in the country, has been much interested in the program of the Milwaukee society.

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The schedule of health talks given, and to be given, by the members of the Speakers' Bureau, sponsored by the Society, is as follows:

"What You Should Know About Your Heart," by Dr. L. M. Warfield, Gyro Club, Sept. 17.

"Character Formation In The Child," by Dr. H. W. Powers, P. T. A. Fratney School, Sept. 17.

"Mental Hygiene Of Adolescence," by Dr. D. W. Roberts, P. T. A. St. Sebastian's School, Oct. 6.

"Character Formation In The Child," by Dr. H. W. Powers, P. T. A. Fernwood School, Oct. 12.

"How Is Your Health?" by Dr. D. W. Roberts, 20th Century Topic Club, Wauwatosa, Oct. 26.

"Character Formation In The Child," by Dr. H. W. Powers, P. T. A. Maryland Ave School, Jan. 6, 1932.

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The first meeting of the Misericordia Hospital staff was held on October 5th, and the following officers were elected for the coming year: Dr. W. J. Murphy, President, Dr. B. H. Oberembt, Vice-President, and Dr. H. F. Wolters, Secretary and Treasurer.

—△—

The Medical Business Bureau has made splendid progress in the short time in which it has been operating. Mr. Gregory Gramling, manager, reports

that more than one hundred physicians are now using the bureau, and that the number is increasing daily.

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Dr. E. L. Miloslavich addressed the Kiwanis Club at West Allis, on March 25, on the "Criminological Analysis of the Greenwald–Kelly and Hoover–Bosshard Murder Cases". He spoke on the "Surgical Pathology of the Kidney" at the joint meeting of the Waukesha County Medical Society and United States Veterans' Hospital ‡ 37 staff, at Waukesha on May 6. The "Criminological Analysis of the Schmitutz–LeVine and Hackett–Perry Murder Cases" was the subject of his talk to the Propellor Club on May 12.

—△—

Dr. and Mrs. Henry O. McMahon, who have been spending the summer at their summer home at Fox Point, have returned to the city. Dr. and Mrs. McMahon recently attended a medical convention at Cincinnati, Ohio.

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Dr. A. J. Rudolf has been elected Chef de Gare of the 40 and 8 Society, Voiture No. 85.

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The annual meeting of the Radiological Society of North America, composed of physicians who are specialists in the use of x-ray, radium, and other forms of irradiation, opens November 30, in St. Louis. Among the speakers listed on the program are the following Milwaukee physicians: Dr. Harry B. Podlasky, Vice-President of the Society, Dr. Joseph J. Eisenberg, and Dr. Norbert Enzer. Dr. Joseph Colt Bloodgood of Johns Hopkins University, a native Milwaukeean, is also on the speakers' program.

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Dr. and Mrs. A. J. Weber recently visited New York, where Dr. Weber attended a medical convention.

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Mr. Gregory Gramling, manager of the Medical Business Bureau, addressed the members of the Actomist Club on October 20th, on "The Legal Aspects of Socialized Medicine."

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Dr. William L. Herner recently returned from New York, where he attended a medical convention.

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Dr. Louis Warfield had as his house guests Dr. Louis Hammon of Baltimore and Dr. Campbell Howard of McGill University, Montreal, who attended the International Assembly of the Inter-State Postgraduate Medical Association of North America.

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Dr. Leon Hirsh, until recently a resident of Milwaukee, now assistant surgeon of the United States Marine Hospital at Detroit, was the guest of his parents during the International Assembly, October 19–23.

The Medical Society of Milwaukee County is very much pleased with the response made by the Milwaukee hospitals to its request for cooperation in the establishment of a Bureau for Blood Donors. All of the hospitals have agreed to aid the Society in sponsoring this Bureau, which, it is expected, will open on or about November 1st.

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Dr. George A. Harlow recently enjoyed a ten day trip to Philadelphia and New York.

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Mr. A. Lawrence Abel, chief surgeon of the Cancer Hospital, London, England, spoke before a most enthusiastic audience when he addressed the Rotary Club at their meeting at the Athletic Club on October 20th. He spoke on the progress being made in cancer study. Mr. Abel was introduced by Dr. J. Gurney Taylor.

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At a meeting of the Child Welfare and Public Nursing Committee, on October 14th, at which Miss Erna Kowalke and Mrs. Polly M. Donnelly, president of the Visiting Nurse Association, were present, the Committee agreed that they would be very glad to cooperate with the Visiting Nurse Association, who, in a recent communication directed to the Society, informed that body that if agreeable to its members the Association would in the future refer all of their medical problems to the Child Welfare and Public Nursing Committee.

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A meeting of the Educational Committee of the Medical Society of Milwaukee County was held on October 15th, at which members were informed that a course in public speaking would be held the latter part of October. Professor H. L. Ewbank, of the department of public speaking, University of Wisconsin, will conduct the course in both elementary and advanced public speaking.

The following postgraduate medical courses were decided upon, to be given during the winter months: Diseases of the Nervous System, the Heart, and Surgical Diagnosis of the Abdomen.

It was planned that each course should consist of five sessions; the first session to be attended by all those enrolled, for which an outside speaker would be obtained. The four remaining sessions are to be conducted by local men, in small groups. All courses are open to Society members without charge.

It was agreed that the first course—Diseases of the Nervous System—should begin about December 1st.

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At a meeting of the special committee on the care of the indigent of Milwaukee County, held on October 16th, hospital costs were discussed.

ENGAGEMENTS

Dr. Paul J. Purtell, son of the late Dr. E. J. Purtell of Milwaukee, to Miss Irene Luebke of Milwaukee.

BIRTHS

A daughter to Dr. and Mrs. J. J. O'Hara, Milwaukee, September 21st.

A son to Dr. and Mrs. Herbert Schmidt, Milwaukee, September 21st.

A son to Dr. and Mrs. R. S. Hirsch, Viroqua, on August 11th. Mrs. Hirsch is the daughter of Dr. Wilbur N. Linn of Oshkosh.

A son to Dr. and Mrs. Irving B. Love, Milwaukee, September 14th.

A daughter to Dr. and Mrs. J. R. Dundon, Milwaukee, September 14th.

MARRIAGES

Dr. Oscar A. Sander, Milwaukee, to Miss Miriam E. Wright, daughter of Dr. Charles A. Wright of Delavan, at St. John's Lutheran Church, Madison, October 12th.

DEATHS

Dr. Benjamin C. Brett, Green Bay, President of the State Medical Society of Wisconsin in 1894, died at his home on October 10th in his ninety-ninth year.

Dr. Brett was born in Strong, Maine, on August 23, 1833. He graduated from Dartmouth Medical School in 1860 and after one year of internship in New York City, came to Highland, Wisconsin, to practice medicine. He remained there until the outbreak of the Civil War, serving during the war as assistant surgeon in the 21st Wisconsin volunteer infantry and was with Sherman on his march to the sea. In 1872 he moved to Green Bay.

For more than twenty years he served as health officer of the city of Green Bay, and drafted the first plumbing ordinance in the city. He was one of the organizers of the Brown–Kewaunee County Medical Society. For several years he served as chief surgeon at Wisconsin Veterans' Home at Waupaca, and while practicing in Green Bay was at one time chief surgeon for all of the railroads in the city. He retired from active practice about fifteen years ago.

Dr. Brett was an honorary member of the Brown–Kewaunee County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by one daughter, Mrs. T. J. Oliver of Green Bay; two sisters living in California, and five grandchildren, one of whom is Dr. James B. Oliver of Ripon.

Acting as pallbearers were Drs. J. R. Minahan, H. A. Wolter, R. C. Buchanan, W. H. Bartran, A. O. Olmsted, and H. P. Rhode, all members of the Brown–Kewaunee County Medical Society.

Dr. Richard A. Dreyer, Wheeler, died on September 24th at his home in Wheeler.

He was born in the year 1887 and was a graduate of Marquette University School of Medicine in 1913. He came to Wheeler from Milwaukee eighteen years ago and during the World War served overseas as a first lieutenant.

Dr. Dreyer was a member of Eau Claire and Associated Counties Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his widow.

Dr. Henry V. Ogden, Milwaukee, died at his home on October 12th following a long illness.

Dr. Ogden was born in New Orleans in 1858 and during the Civil War moved with his family to Brockville, N. Y. He received his medical education at McGill University Faculty of Medicine, graduating in 1882. Shortly thereafter, Dr. Ogden came to Milwaukee and practiced until 1927, when he retired.

He was one of the founders of the Milwaukee Academy of Medicine and for years was a member of the staff of Milwaukee hospital. He was also instrumental in establishing Columbia and Milwaukee Children's hospitals.

Dr. Ogden was an honorary member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

He is survived by his widow, one son and one daughter.

SOCIETY RECORDS

New Members

Raymond B. Dryer, Morrisonville.

Everett B. Keck, 1 West Main St., Madison.

Chas. E. Lyght, Wisconsin General Hospital, Madison.

C. E. Roach, Wisconsin General Hospital, Madison.

Paul L. Eisele, Ripon.

Changes in Address

C. L. Longstreth, Rice Lake to Bellingham National Bank Bldg., Bellingham, Wash.

David Wigod, Milwaukee to Weimar Sanatorium, Weimar, Calif.

C. F. Harris, Brush, Colo., to Bloomington.

C. A. DeWitt, Racine to 807 Hanselman Bldg., Kalamazoo, Mich.

M. W. Trentzsch, Evansville to Highland.

Philip Desbois, Peshtigo to 548 Main St., Oconto.

Alfred J. Roach, Ashland to State Dept. of Health, Albany, N. Y.

P. L. Heitmeyer, Appleton to 415 So. 42nd St., Philadelphia, Pa.

E. C. Quackenbush, Sturgeon Bay to 964 No. 35th St., Milwaukee.

AMERICAN COLLEGE OF PHYSICIANS

The Sixteenth Annual Clinical Session of the American College of Physicians will be held in San Francisco, California, April 4–8, 1932. The headquarters in San Francisco will be the Palace Hotel, where the general scientific sessions, registrations, and exhibits will be held. Clinics will be conducted in various hospitals and institutions in San Francisco and near-by communities.

Because of the life-long interest of Dr. Stephen M. Babcock in the welfare of the farm and the farmer and by reason of his keen interest in young people seeking an education, a plan has been worked out whereby the Babcock residence in Madison will be used to accommodate needy farm boys attending the Wisconsin college of agriculture. The furniture used by the Babcock family has largely been taken over by the State Historical Society and the house has been re-equipped with dormitory furniture. A graduate student has been placed in charge of the residence and 26 young men have been accommodated in the Babcock house.

* * *

Deaths from appendicitis in Wisconsin last year reached a total of 534, marking an increase of 95 fatalities over the corresponding item for 1929. The five-to-nine-year age group suffered most heavily, losing 56 of its members from this cause.

* * *

In three months this year more persons died from heat effects in Wisconsin than during the 14-year span from 1917 to 1930, according to the report of the state board of health.

The bureau of vital statistics of the board received reports of 383 deaths from June 1 to August 30, 1931. From 1917 to 1930 there were 238 deaths attributable to the heat or 145 less than the number which succumbed during the three months this summer.

* * *

A total of 767 deaths from all causes among Wisconsin men and women in their early thirties marked a reduction of 75 from the toll of the preceding year, according to the bureau of vital statistics.

Lowering of both tuberculosis and accident death lists made this unusual gain possible. Tuberculosis was the principal cause of death in this age group, taking a toll of 155 lives, 34 less than in 1929. Cancer jumped from sixth to third place among the leading death causes among the 30-to-34-year group, taking 85 lives as compared with 44 in 1929. Heart diseases were fourth in importance and women of this group suffered 73 deaths from puerperal causes.

* * *

Wisconsin stillbirths in 1930 totaled 1,639 cases, marking an increase of 56 cases over the state's ten-year average annual toll of 1,583.

* * *

Only 33 wells among the water supplies of 650 Wisconsin resorts remain unsafe, and these have been abandoned pending correction, according to the report submitted to the State Board of Health by Walter G. Mase, director of the Board's division of hotels and restaurants.

Pursuant to a resolution adopted by the Board in January, a survey of the state's resorts was undertaken in April to safeguard their water supplies, and containers were made available for submitting samples of water to the nearest branch of the state laboratory of hygiene.

* * *

The conviction of James L. Hawkins in the Milwaukee district court on charges of using the title of M. D. without obtaining a Wisconsin license to practice medicine was affirmed by the state supreme court in October.

Hawkins contends that he is a graduate of an Illinois medical college, and although not personally licensed to practice in Wisconsin, is president of the American Society for Conservation of Vision, Inc., an Illinois firm, which is licensed in this state.

He said the society leased offices in a Milwaukee building, and that he, as president, signed the lease, affixing his signature with the title M. D. for purposes of identification. He said the manager of the office building put his name on the door of the office in that way.

He was arrested in Milwaukee, Feb. 6, was found guilty in the district court and appealed to the Milwaukee municipal court, which affirmed his conviction. He then appealed to the supreme court.

In affirming the $100 fine of both the Milwaukee district and municipal courts against Hawkins, the state supreme court held that the evidence showed the defendant had supervised opening of the office and had visited it several times and could have had the letters taken off the door.

* * *

The crippled children division of the state department of public instruction has estimated that there are 8,500 crippled children in the state. The records include only those cases under 21 who are of normal mentality and for whom medical or educational aid can be obtained. Among the significant facts revealed by the division is that infantile paralysis is responsible for almost a third of the crippling among children in Wisconsin and that almost a third of the orthopedic cases in the state are crippled when they are born.

* * *

Although the new Wisconsin Orthopedic hospital was built to accommodate 113 children, approximately 128 orthopedic cases are now being cared for at the institution, which was opened June 1, 1931.

The largest orthopedic clinic ever held in the state was at Menomonie, July 25, with 117 crippled children examined by Dr. H. C. Schumm and Dr. W. P. Blount of Milwaukee. Dr. R. E. Burns of Madison examined 76 children at Sparta on June 25, and 57 children were examined at Whitehall by Dr. F. J. Gaenslen, Milwaukee. Clinics are planned for other counties of the state in the fall.

» » » CORRESPONDENCE « « «

APPRECIATIVE

2611 N. 2nd St.,
Milwaukee, Sept. 26, 1931.

Mr. J. G. Crownhart, Sec'y.,
State Medical Society of Wis.,
Madison, Wis.

Dear Mr. Crownhart:

I am in receipt of yours of Sept. 23rd notifying me that the Council, at its recent meeting, had elected me as an honorary member of the State Medical Society.

For this honor I heartily thank the members of the Council.

Such an honor is very gratifying to an old man who is permanently on the shelf.

Very cordially yours,

G. J. KAUMHEIMER, M. D.

"BEST WARNING"

Sept. 24, 1931.

Mr. George Crownhart,
Madison, Wis.

Dear Friend Crownhart:

I received your letter relative to collection agencies and I sincerely believe that it is the best warning ever sent out from the State Medical office. I have had some expensive experience and I think your warning is a just one and merits the respect and consideration of every doctor in the state of Wisconsin. I begin to fully appreciate the wonderful work the association is doing for the profession, and I look forward to some great achievements in the future.

Thanking you for your splendid advice, I remain

Respectfully,

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Third Councilor District Invites Members to Annual Meeting at Madison on Friday, November 13th

Members of the State Medical Society of Wisconsin are cordially invited to attend the annual meeting of the Third Councilor District to be held on Friday, November 13th, the day prior to the Ohio State–Wisconsin homecoming game at Madison. The program for the meeting includes clinics at the several hospitals on Friday morning, a luncheon at the Loraine Hotel at noon, with an afternoon scientific program at the Medical School building. The program follows:

10:00–12:00. *Madison General Hospital*
Clinical Demonstration and Discussion of Roentgenological Problems.
Drs. Ellis, Littig, Pohle and Sisk.

10:00–12:00. *Surgical Clinics*
Madison General Hospital.
Methodist Hospital.
St. Mary's Hospital.
Wisconsin General Hospital.

10:00–12:00. *Bradley Memorial Hospital*
Neurological Clinic.
Drs. Lorenz, Bleckwenn, and Reese.

10:00–12:00. *St. Mary's Hospital*
Obstetrical and Gynecological Problems.
Drs. Schneiders, Harper, Harris and Campbell.

10:00–12:00. *Wisconsin General Hospital*
A. Genito-urinary Problems.
Drs. Sisk, Ewell, and Wear.
B. Medical Problems.
Drs. Middleton, Sevringhaus, Van Valzah, Blankinship, Marsh and Kurtz.
C. Pediatric Problems.
Drs. Gonce, Carter, Tenney, Weston, Johnson.

12:15 Luncheon—Loraine Hotel.

2:00 P. M. *Scientific Program*
Service Memorial
Institute Room 230
1. Vitamins in Nutrition.
Dr. Helen T. Parsons, Associate Professor of Nutrition, University of Wisconsin, Madison.
2. Vitamin Therapy.
Dr. Joseph Brewermann, Chicago, Illinois.
3. The Early Treatment of Injuries.
Dr. O. R. Lillie, Milwaukee, Wisconsin.
4. Cerebrospinal Injuries.
Dr. Roland Klemme, Assistant in Clinical Neurological Surgery, Washington University School of Medicine, St. Louis, Missouri.

Dr. E. F. Schneiders, Madison, is President of the Third Councilor District and Dr. J. W. Gale, Madison, is Secretary. A letter to be forwarded to the members throughout the state early in November will offer means of securing tickets to the football game on Saturday for those who wish to remain in Madison over the week-end.

Pregnancy Test Available to Wisconsin Physicians; University Announces Cost Service Effective at Once

Beginning in November, the University of Wisconsin Medical School offers to the members of the medical profession in the state the laboratory diagnosis of pregnancy. The use of small animals into which urine from pregnant women is injected has been described in numerous papers in the medical literature of the last few years. These methods have been used widely enough in European and American laboratories now to make dependence upon them justifiable. Although there is no single test in medicine which merits interpretation into clinical diagnosis without consideration of the clinical picture as a whole, some tests have a high degree of precision. It appears that either the use of the rat or the rabbit as test animals is one such very accurate method of recognizing pregnancy. The dependability of these procedures is shown by the reports of Magath and Randall in the June 6, 1931, issue and of Eberson and Silverberg in the June 27 issue of the Journal of the American Medical Association.

At the University of Wisconsin the endocrinological studies of Dr. Hisaw and his associates in the department of biology have been so fruitful as to make clinical application desirable. These researches have been directed toward an understanding of the physiology of the pituitary and the ovary in several species of animals. Quite as an unexpected application of this work it became evident that clinical observation of pituitary and ovarian disorders would be a helpful control on this work, and also that the results of the animal work would be valuable in the clinic. Consequently the collaboration of the gynecological and the metabolic services was arranged and an animal test laboratory was developed for use with the clinical material. The tests which this laboratory has been making involve techniques similar to the methods now current in a few larger laboratories for diagnosing pregnancy. For some months past these examinations of urine from supposedly pregnant women have been made for the clinicians in the Wisconsin General Hospital and for a few other interested medical men. The success of this service has become so definite that it has led to the plan for giving a similar diagnostic service to all the members of the profession in the state who desire it.

The importance of the test is in the early diagnosis of pregnancy as distinct from other causes of amenorrhea, from other abdominal tumors, or from other causes of nausea, etc. The recognized disturbing factors in the tests can be largely avoided if the clinician will report any evidence of pituitary disease, malignancy, or of possible abnormal pregnancy. In addition to these very simple data it is necessary to submit a sample of about 8 ounces of urine, preserved in a clean bottle by the addition of 2 teaspoonsful of boric acid. The tests will be done at present by at least two methods, to reduce chances of error. It is hoped at present that by the use of these large samples of urine further refinements may be made, leading to more prompt diagnosis and possibly to the differentiation of ectopic pregnancies, recent abortions, or retention of placental tissue. These will be added as rapidly as the test proves dependable for such differentiation.

The use of animals in this way is necessarily expensive. The service can be extended only if the cost of the tests is met by those who use the laboratory. It will be done on a cost basis as nearly as can be determined. Based on experience so far, a charge of $5.00 per sample submitted will be made at present to cover this cost. This rate may be altered as experience shows changes necessary. The result of the examination of a urine sample will usually be available within less than a week if the volume of work is not too great. A probable diagnosis can often be made within 36 hours, if time is an important fact, as in suspected ectopic pregnancies. Such cases should have special requests made for prompt answer.

Samples should be mailed to Dr. E. L. Sevringhaus, at the Wisconsin General Hos-

pital, and remittances should be to the Hospital. The data which should accompany each sample are as follows:

Patient's name (or identifying initials) -------- -------- Age ----.

Probable duration of pregnancy-------- -------- Date of sample------.

Evidences of possible abnormal pregnancy, etc., -------- --------.

Physician's name -------- -------- Address -------- --------.

Chiropractors Inaugurate 1933 Legislative Program; Request Title "Doctor", Entrance to Hospitals and Quarantine Cases and ask Exemption from Basic Science Law

Wisconsin chiropractors will have a fourfold legislative program for 1933 if they adopt the resolutions passed by their Southeastern District Society which has requested the state organization to press for adoption of the following laws:

1. "Concentrate all efforts to have all Chiropractors exempt from the Basic Science examination".
2. Permit chiropractors to use the title "Dr." and "Doctor" provided that they append the further "title or degree of D. C. or Chiropractor."
3. Amend the present quarantine law "to legally permit the attendance and treatment by licensed Chiropractors in Wisconsin in cases of contagious and communicable disease."
4. "Take such steps as are necessary demanding from the state and county officials the right to every licensed Chiropractor to enter state and county hospitals and institutions to administer Chiropractic spinal adjustments to those demanding or in need of such treatment."

It is understood that work is now under way to pave the way for these enactments. Among the preparatory measures a request is made that each Chiropractor advise the secretary of names of those who have failed the Basic Science examinations in Wisconsin. The secretary states "this information can be used to a mighty fine advantage in the fight against that board of examiners."

Milwaukee and Polk Counties Emphasize Periodic Health Examinations by Society Demonstrations

During October both Milwaukee and Polk counties societies emphasized the importance of periodic health examinations by devoting a special program to these subjects. The Polk County Medical Society was addressed by Dr. R. G. Leland, Bureau of Economics of the American Medical Association, Chicago; Dr. W. A. O'Brien of the University of Minnesota, Minneapolis, and Dr. C. B. Wright of Minneapolis, former president of the Minnesota State Medical Association. As guests of this meeting the Polk County Medical Society had members from Barron and St. Croix counties, Wisconsin, and Washington, Chisago, and Pine counties, Minnesota.

For the past two years The Medical Society of Milwaukee County has been actively interested in various phases of preventive medicine and has sponsored a number of activities for the purpose of stimulating the interest of the profession.

Among the postgraduate courses given, the course in chest diagnosis received notable recognition. Other activities sponsored by the Society included the diphtheria prevention campaign, public speaking courses, speakers' bureau, and periodic health examinations.

To further the interest of the profession in examinations a demonstration of the form developed by the Educational Committee of the Society was held at the Academy of Medicine on Spetember 30th. It was the first demonstration of its kind,—to the knowledge of the officers of the Society,—which had been sponsored by a large county medical organization.

Members of the committee, although realiz-

(Continued on page 944)

PRESS SERVICE OF STATE MEDICAL SOCIETY

No serum does so much for public health as printer's ink

PIMPLES

Madison, Wis., Sept. 23—People will bear up philosophically under an incapacitating illness or even where one threatens life, whereas the moment they suffer from a relatively trivial ailment affecting their personal appearance, they are distressed beyond measure. Most people worry more about pimples on the face than they do about a malignant disease.

The Educational Committee of the State Medical Society of Wisconsin declares that most of the pimples which people have cause little trouble to their health. Most of these disturbances are caused by the excessive secretions of the skin glands.

"Few serious diseases so completely upset the mental equilibrium of the girls and the collegiates as ordinary acne," declares the bulletin issued today. "For pure pathos, one has but to recall the school girl looking sadly at her mottled complexion in the mirror of the slot machine and then glancing enviously at the billboard picture of the woman with 'that school girl complexion.'

"The tragic thing about the pimple is that it breaks out ruthlessly on the most conspicuous part of the body and at an age when everyone is extremely anxious to look his best.

"It is important to recognize the fact that the pimple itself is due to infection. For this reason, it is unsafe to use the same towels as a person with acne; but, as a matter of fact, it is not easy to spread the infection to the healthy skin by the towel. Apparently, the soil must be prepared for the infection; that is, the skin with the over-active sebaceous glands resulting in the formation of blackheads, is the one on which pimples are prone to develop. If the sebaceous glands are not over-active, pimples are rare.

"The person with pimples is more likely to reinfect himself than to infect others. Being self-conscious, he is apt to have a habit of fingering the eruptions and then touching the healthier areas of the skin. In this manner the eruptions are spread from one place to another. It is important for the person with pimples to avoid fingering his face, because of the fact that his skin with its over-active sebaceous glands is especially prone to infection.

"The underlying cause of the bad complexion is the disturbance responsible for the over-activity of the little sebaceous glands. The most important cause for the broken-out-complexion is undoubtedly youth. At the age of adolescence many of the glands of the body are disturbed in their equilibrium and likely to be over-active. The sebaceous glands are not an exception to the general rule.

"The most consoling thing about pimples is that they seldom persist after the age of 30."

* * *

ATHLETICS

Madison, Wis., Sept 30—Failure of women to participate in strenuous major athletics is no indication that they are less healthful than men. For many years colleges and health authorities have been attempting to decide whether men or women as a class were the more healthful.

"It is an open question whether women in general are in poorer health than men," declares the athletic health bulletin issued by the State Medical Society of Wisconsin today. "The exclusive participation of men in major athletics will not solve the problem, because a relatively few men enter the sport.

"If, however, we accept for argument that they are less healthy, is one of the contributing factors the strenuous athletic program indulged in by some men, and, by many people, considered too heavy for women? It is scarcely likely that such is true. In the first place, we have no means of determining whether or not the usual competitive sports ordinarily deemed strenuous are beneficial to health. It is probable that too small a proportion of men, even in colleges and universities, engage in such sports to make definite conclusions possible. Then, too, the comparatively small number of individuals in major athletics usually constitutes a superior physical group whose health rating, barring injury and contagion, is high.

"Almost everyone will admit that many underpar individuals can be greatly benefited by exercise and sport carefully prescribed for their particular needs. The value of exercise, especially of the recreative type, cannot be underestimated; neither can the harmful effect of too strenuous competition in certain sports for some individuals be under-emphasized. In the past two decades, particularly, we find many women engaging in the most strenuous type of competitive athletics with just as much safety, apparently, as their brothers. True, the proportionate number of women doing this is less than the number of men, but if we believe the press it is increasing rapidly.

"It seems impossible to make definite comparisons between the health of men and women in general in relation to their participation in athletics for one reason, because so many of both sexes engage in similar sports. Most physicians and physical educators believe that girls should be permitted to indulge in whatever sports and activities, no matter how strenuous, suit their fancy if their physical state warrants. It is generally recommended, also, that they continue with their usual activities."

* * *

HIGH SCHOOL ATHLETICS

Madison, Wis., Oct. 7.—Sports are good for high school students but no pupils suffering from any ailments should be permitted to enter. The Educational Committee of the State Medical Society of Wisconsin today branded as "simply bunk" statements that athletic sports are too strenuous for high school boys.

"It is not the sport that is injurious for high school boys but whether a particular student is fitted for the specific sport," declares the second athletic health bulletin to be issued by the Medical Society. "The elimination of the physically unfit from certain sports is of the utmost importance, not only because of the harmful effect upon the individual but also because of the prejudices which might arise against certain sports should participants, not physically fit, be permanently invalided or worse. It is to be emphasized that such examinations must not be cursory and incomplete. When such is the case, matters are usually worse than when no examinations are made, as students and parents are given an unwarranted feeling of security.

"If among students of college age, as is certainly true, many defects and conditions are found which bar these individuals from some specific or all work in athletics, why will not the same proportionate num-

(Continued on page 942)

THE JOURNAL BOOK SHELF

Gould's Medical Dictionary. By George M. Gould, A. M., M. D . Edited by R. J. E. Scott, M. A., B. C. L., M. D. Third edition, revised and enlarged, based on recent medical literature; 1538 pages; with illustrations and one hundred and seventy-three tables, including three new tables of bacteria, metazoa, and protozoa pathogenic to man and animals by D. G. Bergey. P. Blakiston's Son and Company, Philadelphia, 1931. Flexible fabrikoid $7.00, indexed $7.50. Rigid fabrikoid, indexed $7.50.

Health on the Farm and in the Village. C. E. A. Winslow. Professor of Public Health, Yale School of Medicine. (Macmillan. 1931).

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1930. Cloth. Price, $1.00. Pp. 91. Chicago: American Medical Association, 1931.

Easier Motherhood. By Constance L. Todd. Price $2.00. John Day Company, Inc., 386 Fourth Ave., New York, N. Y.

New and Nonofficial Remedies, 1931, containing descriptions of the articles standing accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1931. Cloth. Price, postpaid, $1.50. Pp. 481 + LVI. Chicago: American Medical Association, 1931.

Proctoscopic Examination and the Treatment of Hemorrhoids and Anal Pruritus. By Louis A. Buie, B. A., M. D., F. A. C. S, section on proctology, the Mayo Clinic, Rochester, and associate professor of surgery, The Mayo Foundation, University of Minnesota. Octavo of 178 pages with 72 illustrations. Philadelphia and London: W. B. Saunders Company, 1931. Cloth $3.50 net.

Diagnostic Methods and Interpretations in Internal Medicine. By Samuel A. Loewenberg, M. D., F. A. C. P., associate professor of medicine, Jefferson Medical College; assistant physician to the Jefferson Hospital; visiting physician to The Philadelphia General Hospital, the Northern Liberties Hospital and the Eagleville Sanatorium for Consumptives. With 547 illustrations, some in colors. Second revised edition. Price $10.00 net. F. A. Davis, Company, Philadelphia. 1931.

A Clinical Study of Addison's Disease. By Leonard G. Rowntree, M. D., and Albert M. Snell, M. D., Division of Medicine, the Mayo Clinic and the Mayo Foundation, Rochester, Minnesota. 12 mo. of 317 pages with 41 illustrations. Philadelphia and London: W. B. Saunders Company, 1931. Cloth, $4.00 net.

Cutaneous X-Ray and Radium Therapy. By Henry H. Hazen, A. M., M. D. Professor of dermatology, Medical Department of Georgetown University; professor of dermatology, Medical Department of Howard University; Member of American Dermatological Association, American Roentgen Ray Society. Illustrated. Price $3.00. C. V. Mosby Co., St. Louis, Mo. 1931.

Bedside Interpretation of Laboratory Findings. By Michael G. Wohl, M. D. Associate Professor of experimental medicine, Temple University Medical School; chief of Metabolic Clinic, Temple University Hospital and chief of the First Medical Diagnostic Clinic, Mt. Sinai Hospital, Philadelphia, Pa. Illustrated. Price $6.00. C. V. Mosby Company, St. Louis, Mo. 1931.

Medical Jurisprudence. By Carl Scheffel, Ph. B., M. D., LL. B. Price $2.50 net. P. Blakiston's Son & Co., Inc., 1012 Walnut St., Philadelphia, Pennsylvania.

BOOKS RECEIVED FOR REVIEW

Gynecology And Urology for Nurses. By Samuel S. Rosenfeld, M. D., F. A. C. S. Adjunct obstetrician and gynecologist Lebanon Hospital, New York City; lecturer in obstetrics and gynecology to Lebanon Hospital School for Nurses; diplomate of the American Board of Obstetrics and Gynecology. Price $2.00 net. William Wood and Company, New York. 1931.

Surgical Pathology of the Genito-Urinary Organs. By Arthur E. Hertzler, M. D., surgeon to the Agnes Hertzler Memorial Hospital, Halstead, Kansas; professor of surgery, University of Kansas. 222 illustrations. J. B. Lippincott Company, Philadelphia.

Surgical Pathology of the Diseases of Bones. By Arthur E. Hertzler, M. D., surgeon to the Agnes Hertzler Memorial Hospital, Halstead, Kansas; professor of surgery, University of Kansas. 211 Illustrations. J. B. Lippincott Company, Philadelphia.

Approved Laboratory Technic. Prepared under the auspices of The American Society of Clinical Pathologists by John A. Kolmer, M. D., Dr. P. H., professor of pathology and bacteriology, Graduate School of Medicine, University of Pennsylvania; professor of immunology and chemotherapy, School of Medicine, Temple University; head of Department of Pathology and Bacteriology, Research Institute of Cutaneous Medicine; and Fred. Boerner, V. M. D., associate professor of bacteriology, Graduate School of Medicine, University of Pennsylvania. With 11 colored plates and 300 illustrations. D. Appleton & Company, New York. 1931.

Bulletin of the National Research Council. Number 83. A compendium of the statute law of coroners and medical examiners in the United States. By George H. Weinmann. Issued under the auspices of the committee on Medicolegal Problems National Research Council of The National Academy of Sciences, Washington, D. C. 1931. Price $3.00.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, 424 N. Charter Street, Madison, Wis.

The Letters of Dr. Betterman. By Charles Elton Blanchard, M. D. Medical Success Press, 36 N. Phelps St., Youngstown, Ohio. 156 pages, Price $1.00.

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brought out in a revised edition. They depict the ideals of an old-fashioned country practitioner in the form of advice to a son about to become a city hospital specialist and are of interest from the point of view of medicine in its several relations. C. R. B.

Collected Paper of the Mayo Clinic and the Mayo Foundation. Volume XXII. Edited by Mrs. Maud H. Mellish Wilson, Richard M. Hewitt, B. A., M. A., M. D., and Mildred A. Felker, B. A. Octavo volume of 1125 pages with 234 illustrations. Philadelphia and London: W. B. Saunders Company, 1931. Cloth, $13.00 net.

This twenty-second annual volume comprises approximately two hundred of the most interesting papers, written by members of the Mayo Clinic and Mayo Foundation, during the past year. In addition, it notes several hundred more papers published, but not included in this edition. Its arrangement by systems adds materially to its value as a ready reference to new methods of diagnosis and treatment.

Under "The Alimentary Tract", two papers are of particular interest. Dr. William MacCarthy's "Review of the Gastric Carcinoma Ulcer Problem" in which he stresses the value of surgery and intelligent after care of the patient, is of real value. "The Function of the Liver in Relation to Surgery", by Dr. Charles Mayo, can be read with profit by any person interested in surgery.

In the genito-urinary section the paper on "Renal Tuberculosis" by Drs. Herman Bumpus and Gershon Thompson, is of particular interest. In this article they show that tuberculous lesions of the kidneys *do* frequently heal. Dr. Frederick Schacht, in his paper on "Hypertension in Cases of Congenital Polycystic Kidney", states that a large portion of polycystic kidneys have persistent hypertension. Dr. Francis Ford's papers on "Irradiation Therapy in Ovarian Disorders", pointing out as it does, the number of pregnancies following five to ten per cent erythema irradiation doses of previously sterile women adds another method of treating these cases.

The ductless gland section contains a paper on "Addison's Disease" and its treatment with various suprarenal preparations, which is of exceptional interest. The paper on "The Feeding of Gastric Tissue in Cases of Pernicious Anemia", by Dr. Conner, offers another method of treating these cases. The paper by Dr. Carl Anderson, in which he rules out sinusitis as a factor in focal infection in 400 cases, is of particular value. R. C. B.

Simple Lessons in Human Anatomy. By C. H. Harvey, M. D., professor of anatomy, University of Chicago. Illustrated. American Medical Association, Chicago.

Health is the expression of harmonious functioning of the various parts of the body with one another and of the body as a whole in relation to the surroundings. Function and structure are so inseparably united that it is impossible to have an intelligent conception of the conditions underlying human health without some knowledge of human structure. Anatomists have collected a vast amount of detailed information concerning human structure but the mass of details has made difficult the presentation of the more fundamental general features of human structure comprehensible to the intelligent layman interested in health. Dr. Harvey prepared for Hygeia a series of articles in which a presentation of this character was attempted. These articles achieved their objective so successfully that they have now been brought out in book form. This book is not only to be recommended to the intelligent layman but will be found of stimulating interest to physicians and nurses professionally engaged in applying knowledge of anatomy to the relief of suffering. C. R. B.

Accidental Injuries. The Medico-Legal Aspects of Workmen's Compensation and Public Liability. By Henry H. Kessler, A. B., M. D., F. A. C. S., F. A. P. H. A.

This book is unique in its field. To anyone interested in the medical questions arising in litigation of accident claims, it presents much valuable information. It is written by a man who by virtue of his position and experience is peculiarly well fitted to write such a book.

It consists of twenty-two chapters and covers almost seven hundred pages.

Chapter one covers a historical review of workmen's compensation laws. Chapter two takes up the medical aspects of these laws. Chapter three takes up schedules of specific injuries. The next two chapters are devoted to the pathology and the end results of trauma. Chapters seven to sixteen inclusive cover the specific injuries of the entire body. Chapter seventeen takes the relationship of injury to disease. Then follows a chapter on traumatic neurosis, another on occupational disease and finally a chapter on the rehabilitation of the physically handicapped.

In this book physicians will find assistance in estimating the period of disability as well as its permanent percentage. Throughout the book the functional pathogenesis of disability is kept constantly in mind. This is as it should be.

The illustrations are quite numerous and are very clear. Each one depicts a type of case and is accompanied by a footnote giving the estimate of disability. This is very helpful.

The book can be recommended to those to whom injured workmen may come, either for their treatment or the establishment of their claim. R. E. B.

The Practice of Medicine. By A. A. Stevens, A. M., M. D., professor of applied therapeutics in the University of Pennsylvania; visiting physician to Philadelphia General and University Hospitals; consulting physician to St. Agnes' Hospital, Philadelphia. Third edition, entirely reset. 1150 pages, illustrated. Philadelphia and London, W. B. Saunders Company, 1931. Cloth $8.00 net.

The third edition of Stevens' Practice of Medicine appears entirely reset, with many additions and al-

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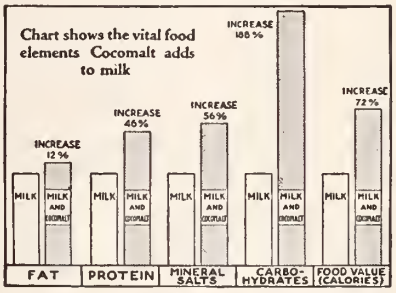

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terations. These do not add materially to its volume yet bring the work up to date, and if possible will add to its deserved popularity among practitioners and medical students.

Among new subjects treated in this edition are psittacosis, toxoid prophylaxis of diphtheria, immunization to scarlet fever and to measles, antitoxin treatment of erysipelas, vaccina encephalitis, massive collapse of the lung, hypo- and hyperparathyroidism and spontaneous subarachnoid hemorrhage.

A number of the sections have been rewritten to conform to more recently accepted conceptions of disease. Among them are the sections on jaundice, chronic cholecystitis, acute pancreatitis and chronic ulcerative colitis; agranulocytic angina, pernicious anemia, acute leukemia, Hodgkin's disease, erythremia, Gaucher's disease, Banti's disease, bronchiectasis, thrombo-angiitis obliterans, coronary disease, scleroderma, rickets, pellagra, thyroiditis, disseminated sclerosis, undulant fever and many others.

In the classification of diseases, to conform to recently accepted ideas, the inclusion of typhus fever, Rocky Mountain spotted fever, and trench fever under the title, "Infections due to Rickettsia Bodies", is a departure from that used in former editions.

A feature which has caused the widespread use of former editions as a work of reference, namely, the stress laid on the more accepted forms of rational treatment, has been adhered to in the present work.

As a text book of medicine, the third edition will more than justify the author's hopes so modestly expressed in the preface. R. V. V.

Clinical Laboratory Methods. By Clyde L. Cummer, Ph. B., M. D., F. A C. P., formerly associate clinical professor of clinical pathology, School of Medicine, Western Reserve University, Cleveland; instructor in dermatology and syphilology, School of Medicine, Western Reserve University, visiting dermatologist, Charity and St. Alexis Hospitals, Cleveland. Third edition, thoroughly revised. Illustrated. Price $6.75. Lea & Febiger, Philadelphia, 1931.

This book has been revised to contain the recent advances in laboratory methods as they pertain to medical diagnosis. Cummer has always faithfully enumerated the details in technique which are essential to correct results. In this revision he has made no exception to this principle. His emphasis on the importance of the simplest detail recommends the book as a text for students. The clinical interpretations are brief but expressive and significant.

The chapter on hematology is particularly well done. In this chapter the author has epitomized present day ideas concerning the origin of the blood cells, described methods used to make these ideas practical, and discussed their clinical significance.

The book is heartily recommended as a text for students and as a reference book for physicians. W. D. S.

Gonorrhea in the Male and Female. By Percy S. Pelouse, M. D., associate in urology and assistant genito-urinary surgeon at the University of Pennsylvania; fellow of the Philadelphia College of Physicians, Philadelphia. Second edition, revised. 440 pages with 92 illustrations. W. B. Saunders Company, Philadelphia and London. Cloth $5.50 net. 1931.

In this second edition, the author has added many new chapters, and a new section on gonorrhea in the female. As stated in the preface to the first edition it is not a text book, but a discussion of the subject in which the author sets forth his own views in a simple and understandable manner. Easy to read, it is a book for practitioners or genito-urinary specialists. I. S.

MEDICAL LIBRARY SERVICE

AN EXAMPLE

September 21, 1931.

Frances B. van Zandt, Librarian,
Medical Library Service,
University of Wisconsin,
Madison, Wisconsin.

Dear Miss van Zandt:

Can you help me to find some literature on the subject of congenital misplacement and malformation of the ureters, kidney and bladder, particularly the ureters and kidney?

Do you know of any small and rather elementary book on embryology; one that a country doctor can read with some degree of understanding?

I want to know about the kidney and ureter of a child three months old. Have you any one who can give me the approximate diameter of such a child's ureter at the pelvic brim or in its lower third? Gray's Anatomy says the adult ureter in that location is from 1/6 to 1/8 inch thick normally. If you cannot tell me I will have to come down to consult some of the anatomists. I called on Dr. Sullivan twice at the U. W. but failed to find him. What is now considered the latest and best anatomy for use of the general surgeon?

You see you conducted me through your excellent library and I now have confidence that you furnish most of the physicians and surgeons with their powder.

Very sincerely,

-------- ------ .

THE SERVICE

September, 24, 1931.

-------- --------, M. D.

Dear Dr. --------:

I thank you for the very liberal praise which you bestowed upon our medical library service. Now the question is whether or not we shall be able to satisfactorily answer the several inquiries which your letter contained.

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malformations of the ureters and kidney have been forwarded to you.

Hemholz & Amberg—Genito-Urinary System [Clinical Pediatrics, Volume XIX].

Morris—Surgical Diseases of the Kidney and Ureters, Volumes I and II.

On page 15 of Helmholz there appears a short bibliography on malformations of the genito-urinary tract. All of those references are available except Ekehorn, Goldstein and Hurt. Probably those could be borrowed from another library if you desire. There are many journals containing articles on like subjects, but this list seems quite comprehensive.

Arey—Developmental Anatomy has also been sent to you. I trust that this will be a satisfactory answer to your request for a good text on embryology.

I have attached a list of the books which we have here on surgical anatomy. Cunningham's "Practical Anatomy" is also very good. We shall be glad to send you any of these for examination.

To return to your inquiry about the size of the ureter in children, the following quotation from Abt's "Pediatrics", Volume I, p. 356, edition of the date 1923 may be of interest to you:

"The ureters are from 6.5 to 7.0 cm. in length in the newborn, being a little less than ¼ as long as in the adult. The left ureter is generally a little longer than the right throughout life. The ureters practically double in length during the first two years together with the growth of the lumbar region; thereafter their growth is much slower. The diameter of the ureter in the infant is always relatively and sometimes absolutely larger than in the adult. The sinuses of the ureter are well marked, and the lumbar one, in particular, is very prominent."

You will note that on page 17 of Helmholz there is a discussion of the diameter of the ureters.

Please advise if we can serve you by sending further references, or any of the texts listed.

Very truly yours,

-------- --------,
Librarian.

BOOKS AVAILABLE FROM MEDICAL SCHOOL LIBRARY ON SURGICAL ANATOMY

Beesly, Lewis and Johnston, T. B.
Manual of Surgical Anatomy, New York, Oxford Med. Pub., 1924.

Deaver, John B.
Surgical Anatomy of the Human Body, Phila., 1926.

Jackson, C. M., Editor
Morris' Human Anatomy, Phila., P. Plakiston, 1925 [On reserve and not available for loan].

Treves, Sir Fred'k.
Surgical Applied Anatomy, Phila., 1918.

Whittaker, C. R.
Manual of Surgical Anatomy, Livingstone, Edinburgh, 1928.

Warren, John
Warren's Handbook of Anatomy, from Original Dissections by John Warren, text by Robt. M. Green, drawings by H. F. Aitken, Harvard University Press, Cambridge, Mass., 1930.

PRESS SERVICE

(Continued from page 935)

ber of grade and high school pupils be similarly affected. It is obvious that the conditions which render it unsafe for these students to engage in physical work are usually chronic and have not been acquired in the short vacation period between high school and college. Most 'prep' schools have recognized the necessity of thorough physical examinations for their students, and many of them are doing enviable work along those lines. It is to be regretted that the public schools have not kept pace with this modern idea of the proper physical examinations of pupils. Usually, financial inability to engage competent physicians to do the work is the cause of this glaring omission in our grades and in high schools.

"It is well known that numerous children and young adults suffer from chronic heart disease; certainly the majority of these should not engage in strenuous sport. Many of these individuals, and even their parents, do not suspect these cardiac conditions and often suffer irreparable injury if allowed to participate in athletics, at least without proper medical supervision. The great so-called rheumatic syndrome is the common cause of these chronic heart conditions. Four related diseases,—acute articular or inflammatory rheumatism, scarlet fever, tonsillitis, and chorea or St. Vitus' dance,—make up this syndrome, and children who have had any one of these infectious diseases should be carefully observed for heart conditions.

"If grade and high school students are physically fit they should ordinarily be permitted to engage in such activities as attract them. Obviously, football in high school is not for the extremely tall, very thin boy, particularly if his height has been acquired in a year or so. Basketball, one of the most strenuous sports, is as safe for high school as for college students, provided the participants are chosen with a view to their age, weight, and general fitness. The same rule should hold for all activities. It is usually not the sport that is too strenuous for high school students, but that a particular student is not fitted for the specific sport."

* * *

THE WEEK-END VACATION

Madison, Wis., Oct. 14—There are more dangers from week-end vacations than good, in the opinion of the Educational Committee of the State Medical Society of Wisconsin. Too much club life, too many engagements, too many week-end trips are more to be blamed for fatigue than the routine of office work.

"The strenuous week-end has become a menace to young people," continues the weekly bulletin of the Medical Society out today. It declares that the strenuous week-end repeated week after week leads to more nervous break-downs than any other single cause.

"In this high tension age of telephones, dictaphones, conferences, interviews, committee meetings, luncheon club engagements, strenuous week-end trips, this is a very important subject," declares the bulletin. "For twenty-five years the tendency has been to increase speed until we have reached the age of little rest for nerve, brain, or muscle. This rising tide of mental and physical tire is interpreted by the business man

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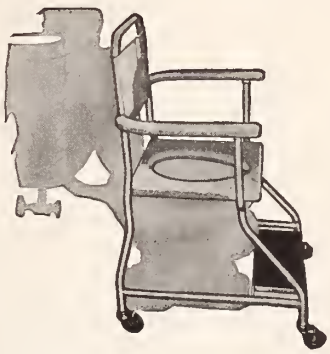

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as a need for more exercise. As a result he tears away from his office Saturday noon, rushes forth for his Saturday–Sunday vacation and crams himself so full of exercise that he is totally exhausted when Monday morning arrives and he is back once again on the job.

"If his exercise is golf, it is too often thirty-six holes instead of eighteen; if it is tennis, it is five sets morning and afternoon; if it is walking, too often it is a strenuous cross country hike with much climbing of hills. Even if it is merely motoring, the trip too often develops into a 'record run' at break-neck speed.

"In fact, the average American has a tendency to go in too much for spasmodic and not enough for regular normal exercise, and hence his 'fatigueometer' too often is registering at its highest point.

"Excessive fatigue is apt to result in digestive disturbances, colds, influenza and other infections. It is particularly bad for those suffering from malnutrition and from nervous disorders. If, after you have made a violent effort, your heart keeps on thumping for more than a few moments, you can be sure that your muscle needs care and training. This is a warning that you should rest before the stage of exhaustion. You should realize also that thorough and beneficial development of the muscles can take place only by making your exertion very real. Physical tiredness is not a condition to be avoided. To be tired is good because the exertion which resulted in that tiredness was good for you. There is a great deal of difference, however, between the man who is tired and the man who is tired out or exhausted. The man who is 'tired' is in need of sleep. The man who is 'tired out' is in need of a physician. If you belong to this 'tired out' class, don't put off too long your visit to your family physician.

"Take care of your muscles. Listen to their complaints. On proper occasion cultivate the art of 'masterly inactivity.' Your muscles will always tell you the truth as to whether you are or are not treating them well. The important thing to remember is that you should heed the advice they give you."

* * *

MENTAL DEPRESSION

Madison, Wis., Oct. 21—There can be no financial depression that is so destructive to the morals of the people as mental depression. Part of the present day disorganization is due to a mental depression which can only be checked by people looking upon more favorable things in life.

The Educational Committee of the State Medical Society in a bulletin issued today warns people against mental depression and declares that people suffering from it are in a worse state than if they had lost all of their money.

"One so affected takes little pleasure in anything, and nothing seems worthwhile," declares the Medical Society's warning against mental depression. "Achievement, which ordinarily should bring happiness, appears hollow and worthless. The depression settles down like a cloud and may last for long periods. Fear of some impending trouble and episodes of nervousness may be associated with it, and the sufferer feels that he may lose all self-control. The anxiety is often worse at night, and sleeplessness and bad dreams result.

"A depressed state of mind does not occur without cause. Occasionally the cause may be quite evident as when a mother broods over the loss of her child, or when there is some underlying physical disorder, depleting vigor and health, but such clear-cut instances of cause and effect are not very common. The real cause is generally in the mental sphere, and people often suffer from mental anxieties and worries, which, unassisted, they find difficult to overcome. There may be family difficulties, personal troubles, loss of position, or frustration of long cherished hopes and ambitions, with a final realization that their full achievement is not possible.

"Various impulses may accompany a state of depression, impulses to leave home, to make a drastic change, even to end it all, and impulses resulting in drunken sprees and other excesses often occur. Action on such impulses is unwise and does not bring relief. The patient carries his worries and fears with him wherever he goes, and the depression after a debauch is worse than before.

"The treatment of depressed states depends upon the underlying causes. When these are of physical nature, improvement in general health brings about mental improvement as well. Mental causes are seldom clearly understood by the patient, and he is much benefited by talking over the entire situation, not once but as often as necessary, with a physician whose experience with many patients gives him an understanding of such conditions. Frequently, persons have distressing problems solved in this way, problems which have troubled them for years out of all proportion to their real importance. The resulting increase in efficiency and happiness is of inestimable value. Needless to say, depressed and nervous persons in their desperation, may become a prey of unscrupulous quacks, who make extravagant promises, but whose treatment is useless if not positively harmful."

SOCIETIES DEMONSTRATE P. H. E.

(Continued from page 934)

ing that the demonstration was an experiment, were confident of an enthusiastic response, and they were not disappointed. Nearly two hundred physicians attended the afternoon and evening demonstrations, and manifested keen interest by a lively discussion of health examinations.

Both the afternoon and evening sessions were conducted by Dr. Edmund F. Foley, assistant professor of medicine, University of Illinois College of Medicine. Dr. Foley opened each demonstration by a fifteen minute discussion on physical diagnosis, then proceeded to analyze the educational committee's periodic health examination form and demonstrate its use.

First consideration was given to the history, and the importance of various questions was stressed. A physical examination was then given with the aid of a subject.

Dr. Foley, who is an excellent speaker, gave a clear-cut and thorough demonstration of what a health examination should be, and made a deep impression on all attending physicians. He was particularly well qualified for this task because of his wide experience in the field of preventive medicine.

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed care Wisconsin Medical Journal.

WANTED—Used bedside x-ray, operating table, office examining desk, sterilizer, etc. Must be in A1 condition. Address Number 856 in care of The Journal. ND

FOR SALE—Office equipment, furniture, rugs, and instruments; terms cash; price $350; in prosperous town, northeastern Wisconsin, 1500 population. Reason for selling owner specializing. Address Number 853 in care of The Journal. N

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OFFICE ASSISTANT DESIRES POSITION. Two years' experience as office assistant. Particularly qualified as physiotherapist and x-ray technician. Has kept books and is typist. Willing to go anywhere in state. Address Miss Helen MacKaben, 710–3rd Ave. N., Wisconsin Rapids, Wis.

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The next step to be taken by the educational committee and the health council of the Society in the interest of these examinations is to develop plans which will make it possible for a great number of physicians to make periodic health examinations. This is a difficult task but one which officers of the Society feel can be accomplished.

Dr. Robert W. Blumenthal is chairman of the educational committee. The other members are Dr. A. J. Patek and Dr. C. C. Schneider.

Woman's Auxiliary Entertains One Hundred

While the members of the State Medical Society were holding their ninetieth anniversary meeting at the Memorial Union Building, Madison, September 9, 10, 11, the wives, mothers, daughters and sisters of the members were entertained by the Woman's Auxiliary.

A reception at the state executive home, 130 East Gilman Street, was an event of Wednesday afternoon. Mrs. Philip La Follette received visitors from 3 to 5 P. M. Delightful music was furnished by a harpist, Miss Margaret Rupp. Assisting Mrs. La Follette were Mrs. C. A. Harper, Mrs. C. R. Bardeen, Mrs. H. J. Gramling and Mrs. Robert La Follette.

The Executive Board held an informal dinner meeting at the Loraine Hotel at 6:30 Wednesday evening. The following officers were present: Mrs. C. R. Bardeen, President; Mrs. Henry Gramling, President-elect; Mrs. Homer Carter, Secretary; Mrs. M. D. Bird, Treasurer; Mrs. Fred A. Nause, Jr., Parliamentarian and President of Sheboygan County; Mrs. Frank Brinckerhoff, President of Rock County and the Executive Secretary, Miss Ruth M. Buellesbach. Nominations were as follows: Mrs. Fred A. Nause, Jr., Sheboygan, President-elect; Mrs. Homer Carter, Madison, Secretary; Mrs. M. D. Bird, Marinette, Treasurer. Mrs. James Blake, 1st Vice-President of the Woman's Auxiliary to the American Medical Association, discussed the work of the Auxiliary.

The principal event of Thursday was the luncheon which was held in the tea room of the Memorial Union Building. Sixty-four women attended the luncheon meeting. Mrs. James Blake spoke on the work of the Auxiliary.

Immediately after the luncheon meeting the ladies were conducted through the State Historical Museum. It houses many treasures, and the tour proved to be an interesting experience for everyone.

After the visit to the Historical Museum, lemonade was served on the terrace of the Memorial Union Building. At 5 P. M. Mrs. Gramling, Mrs. Bird, Mrs. O'Neal, Mrs. Brinckerhoff, Mrs. Bardeen and the Executive Secretary held a short meeting and suggested names for Chairman of the Auxiliary.

At 5:45 P. M. a dinner was served in Tripp Commons for the members and their wives, after which they watched the presentation of the Councilor awards. At 7:30 P. M. the ladies were entertained at a Bridge party in the tea room. Mrs. M. D. Bird won first prize; Mrs. B. E. Scott, second prize; Mrs. Hazelwood, third prize and Mrs. C. A. Harper, fourth prize.

BUSINESS MEETING

Minutes of the business meeting on Thursday noon September 10th, follow:

1. The Auxiliary was called to order by the President, Mrs. C. R. Bardeen, Madison, at 1:30 P. M.

2. President, Mrs. Bardeen: Because of the fact that until 15 County Auxiliaries have been organized, there are no delegates as such, all who are present at this meeting have the privilege of participating in the meeting and casting a vote.

a) The Executive Board of the Auxiliary including the state officers and Presidents of the organized County Auxiliaries met last evening as a nominating committee. I shall ask our Executive Secretary to read the report of that committee after which we shall act on each nomination separately. I am most anxious that you keep in mind, however, this report does not preclude additional nominations from the floor and if any wish to make such nominations, they should have no hesitancy in so doing,—Miss Buellesbach.

3. Executive Secretary: The Nominating Committee has nominated Mrs. Fred A. Nause, Jr., of Sheboygan, for President-elect; Mrs. Homer Carter, of Madison, for Secretary, and Mrs. M. D. Bird, of Marinette, for Treasurer.

4. Mrs. Bardeen: Mrs. Fred A. Nause, Jr., of Sheboygan has been nominated to the office of President-elect. Are there any additional nominations

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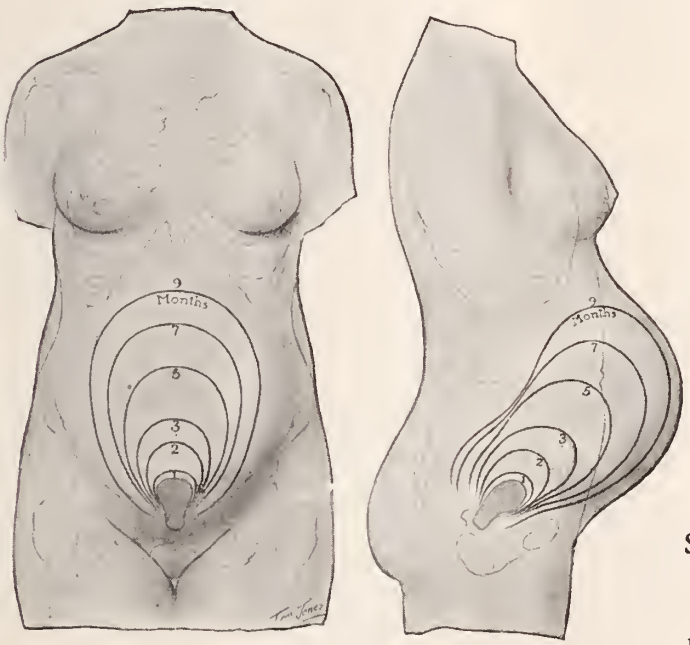

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from the floor? Hearing none, I will entertain the motion to the effect that the Executive Secretary be instructed to cast a unanimous ballot for Mrs. Fred A. Nause, Jr.

a. Moved by Mrs. C. A. Harper, seconded by Mrs. Albert Tormey, that Mrs. Fred A. Nause, Jr., be unanimously elected as President-elect of the Woman's Auxiliary. The motion was carried unanimously.

5. Mrs. Bardeen: Mrs. Homer Carter of Madison has been nominated to the office of Secretary. Are there any additional nominations from the floor? Hearing none, I will entertain the motion to the effect that the Executive Secretary be instructed to cast a unanimous ballot for Mrs. Homer Carter.

a. Moved by Mrs. Albert Tormey, seconded by Mrs. C. A. Harper, that Mrs. Homer Carter be unanimously elected as Secretary of the Woman's Auxiliary. The motion was carried unanimously.

6. Mrs. Bardeen: Mrs. M. D. Bird of Marinette has been nominated to the office of Treasurer. Are there any additional nominations from the floor? Hearing none, I will entertain the motion to the effect that the Executive Secretary be instructed to cast a unanimous ballot for Mrs. M. D. Bird.

a. Moved by Mrs. E. F. Schneiders, seconded by Mrs. Ray Blankinship, that Mrs. M. D. Bird be unanimously elected as Treasurer of the Woman's Auxiliary. The motion was carried unanimously.

7. Mrs. Bardeen: I have always felt that it was hardly fair for a presiding officer to call on someone out of the blue sky, but I do wish you to know each of the State Officers and I am going to call their names that each may stand so that we will all know them. Our President, Mrs. Henry Gramling of Milwaukee. Our President-elect, Mrs. Fred A. Nause, Jr., of Sheboygan. Our Secretary, Mrs. Homer Carter of Madison. Our Treasurer, Mrs. M. D. Bird of Marinette.

8. Mrs. Bardeen: The work of the Auxiliary along state wide lines has been handicapped by the lack of one who could act as its Executive Secretary and assistant in promoting organization of the several counties. Last May our State Medical Society secured the services of Miss Ruth M. Buellesbach, and Mr. Crownhart, Secretary of the Society, promises us a proportion of his time. Some time after the first of the year Miss Buellesbach will be available to visit such counties in the state as wish to form Auxiliaries, and as our executive officer I wish to present her to you at this time.

9. Miss Buellesbach: Madam President, Mrs. Blake and Members of the Auxiliary, it is with real pleasure that I look forward to visiting those sections of the state where our county Auxiliaries have been organized and those other counties that will desire to organize. In the meantime, I trust that none will hesitate to write in care of the State Society, Madison, that the headquarters may be of every possible assistance to you all.

10. Mrs. Bardeen: I presume that most of those present are wives of members of our State Society and I am sure that even those that are not will appreciate the situation when I say that we are always hearing from the men. Now I am happy to advise you that just as this is our Auxiliary so it is our program and our Speaker, for a change, is to be one of us. Among those who visualized the constructive work for the public and the medical profession that might be accomplished through the National, State and County Auxiliaries, was our guest of today. Long National Chairman for the North Central States, at the Philadelphia meeting this year her work was recognized in her election to the office of First Vice-president of the National organization. It is a distinct source of pleasure to me that I present to you now, Mrs. James Blake of Hopkins, Minnesota.

11. Mrs. Blake: (Summary) The one thing we are interested in is the doctor and his problem and we can learn about this through the Auxiliary. There is no other such organization in existence. Mothers, widows, wives and daughters are all members. The Auxiliary activities fall into three groups: Social, Philanthropic and Educational.

During the past year there has been a great deal of correspondence with Wisconsin women. Last May the Medical Society secured an Assistant who will act as a go-between for the Medical Society and the Woman's Auxiliary. She will act as the Executive Secretary for the Auxiliary.

The word Auxiliary means aid and support and we can organize only with the doctors' consent and backing. Every County Auxiliary should have an advisory board consisting of one doctor or more. The Auxiliary is the only organization in which we live up to what our husbands tell us.

The problems of the medical man are his problems and his only. We should occupy a unique position and should be known in every community project. We should be known for standing up for the right idea in everything. As medical wives we should be educated to our jobs.

The Wisconsin Medical Journal is the best Medical Journal in the United States today. You should read the Journal and know what is in it, for it is easy to read and understand. Beginning with the November issue you will receive news of the Auxiliary in the Medical Journal.

12. Mrs. Bardeen: We are indeed appreciative, Mrs. Blake, for your trip to Wisconsin and and for the message you have given us today. I now have the pleasure of presenting the Director of the Bureau of Public Health Nursing, Miss Cornelia Van Kooy, who will say a few words to us.

13. Miss Van Kooy: The department of Public Health Nursing extends their cooperation to the Woman's Auxiliary and we are very glad to learn about the aim and purposes of the Auxiliary to the State Medical Society.

14. Mrs. Bardeen: Before we adjourn I do think you should know the wife of the out-going President, Mrs. C. A. Harper of Madison; also the wife of the

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in-coming President, Mrs. Otho Fiedler of Sheboygan. I call on Miss Buellesbach who has some announcements to make at this time. (The program for the remainder of the day was announced.) Unless there is new business to come before us at this time,—is there any such,—this meeting adjourns and we will cross the street to visit the Historical Museum.

The Shoulders Resolution

At its meeting at Philadelphia last June the House of Delegates of the A. M. A., passed a resolution urging the payment of weekly cash payments during total disability and payment of necessary hospital charges so the veterans can be treated in hospitals of the veterans' own choice.

It is plain that providing new hospitals in such number as would be required would be an enormously expensive undertaking, for which all of us would have to pay; also that another short step would take us to providing this care for wives and children.

For all the citizens of the United States to be taxed to build new hospitals when certain citizens of the United States have already in operation hospitals adequate for rendering efficient an economical care, ready and waiting, is nothing short of reckless waste from one angle, and tyrannous confiscation from another. Be it remembered, these private hospitals were erected to meet real and urgent needs, and those needs will be with us demanding to be met when we World War veterans are as few as now are those of '61 to '65.

In addition—and this is of great importance—under the present plan a veteran receives no benefit in illness unless it be decided that hospitalization is required. The resolution passed by the House of Delegates favors cash benefits for disabling illness in home as well as hospital.

It appears obvious that the substitute plan proposed would be more serviceable, more satisfactory and cheaper as well as more just to veteran, taxpayer, hospital owner and doctor.

Plans are proposed for increasing the number of Government hospital beds still further, although a recent survey indicated that more than 200,000 beds in civilian hospitals are unoccupied and that many private hospitals face ruin for this reason.

All of us know how next to impossible it is to get rid of a Bureau of the Government. Naturally, bureau employees don't wish to lose their jobs. So we can expect every effort put forth to extend the scope of bureaucracy unless it is held rigidly within reasonable limits.

Many American Legion posts have gone on record favoring the Insurance Plan. Let's get vigorously to work toward having our own posts do likewise.

Advantages of the Insurance Plan[1] (as opposed to centralized hospitals) as advocated in the Shoulders Resolution passed by the A. M. A. are:

Under the insurance plan, the benefit is available to every veteran the moment it is enacted into a law.

Under the hospital plan the benefits will not be available to every veteran until sufficient number of hospitals have been built to accommodate the needs of all the veterans.

The insurance plan is of equal benefit to every veteran.

The hospital benefit is of unequal benefit to veterans because the benefits are available to veterans who live near a hospital and are not available to the veterans who live at a distance.

Under the insurance plan the veteran who is disabled draws a cash benefit when disabled from a cause which does not require hospitalization.

The hospital plan is of benefit only to the veteran whose condition requires hospitalization.

Under the insurance plan the family of the veteran would receive the weekly cash benefit during the hospital confinement of the veteran.

Under the hospital plan the family of the veteran receives no government benefit. If the veteran is indigent his family is dependent on community charity.

The insurance plan would be economical to administer, in that government organizations already in existence could administer the law and the veterans would receive the full benefit of every dollar spent by the government.

Under the hospital plan of benefits most of the money would go into construction costs, the cost of equipment, the cost of administration, etc.

Under the insurance plan of benefits when the last need of the last veteran has been served, the plan of service will have been completed and there are no buildings and equipment to be abandoned.

Under the hospital plan of benefits the hospitals would remain open at enormous cost without patients, or the buildings and equipment would be abandoned and the personnel disbanded.

—*Southern Medicine and Surgery*, October, 1931.

[1] From *Jl. Tenn. State Med. Assn.*, Sept., 1931.

STATE SECRETARIES MEET AT CHICAGO

Secretaries of state medical societies will hold their annual conference at the headquarters of the American Medical Association, Chicago, on Friday and Saturday, November 13th and 14th. Those who will attend the meeting from Wisconsin include Dr. Otho A. Fiedler, president, Sheboygan; Dr. A. W. Rogers, Oconomowoc, chairman of the council; Dr. Reginald Jackson, Madison, president-elect; Dr. John Huston, Milwaukee, medical editor; Mr. Theodore Wiprud, Secretary of the Medical Society of Milwaukee County, and J. G. Crownhart, secretary.

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BASIC SCIENCE EXAMINATION

September 19, 1931

PATHOLOGY

Answer *five* of the following questions:

1. Give briefly the differential points between a gumma and a tubercle.
2. Discuss epitheliomata.
3. Describe briefly a normal blood picture—red blood corpuscles, hemoglobin, total and differential leucocyte count, and platelets. How does each vary in pernicious anemia?
4. What different pathological events may follow coronary thrombosis?
5. Describe the gross and microscopic pictures of arteriosclerotic scar in the kidney.
6. Give the pathologic picture in acute appendicitis. What are the chief sequelae?
7. Discuss atelectasis.
8. Define carcinoma; sarcoma; pathology; leucocytosis; anemia.

ANATOMY

1. List the bony structures of the shoulder girdle and the superior extremity which are sufficiently prominent to produce surface elevations, or which can be felt, naming the bone of which each is a part.
2. What movements are possible at the knee joint? Name the muscles which produce each movement. What tendons can be felt in the region of the knee?
   What are the positions of the chief nerve trunks and blood vessels at the knee?
3. Describe the blood supply of the anterior abdominal wall.
4. What would be the evidence of peripheral paralysis of each of the following nerves:
   Oculomotor
   Mandibular
   Hypoglossal
   Musculocutaneous of the superior extremity
   Radial (musculospiral)
   Common peroneal (external popliteal)
5. Answer either (a) or (b):
   (a) Write an organized description of the pharynx.
   (b) Write an organized description of the nasal cavity.

PHYSIOLOGY

1. What is muscle tonus? What is its significance? What mechanisms bring it about?
2. How is the sugar content of the blood kept normal in amount?
3. What is hemoglobin and what are its functions?
4. Discuss the motor control of the skeletal muscles.
5. In what form, and where are the various foodstuffs absorbed?
6. What physiological facts may the physician learn by feeling the patient's pulse?
7. Name the glands of internal secretion and state the functions of each.
8. Describe a reflex arc. What is reciprocal inhibition?

DIAGNOSIS

1. What history, symptoms and laboratory data are necessary to justify a diagnosis of poliomyelitis?
2. What definitely demonstrable body lesions do you recognize as potentially pre-cancerous?
3. A young adult reports a sharp, lancinating pain of a paroxysmal character in the right abdomen; what conditions must be considered, and by what additional data may same be differentiated?
4. (a) What conditions must be suspected in a case of a diarrhea continuing over 3 days, in an adult?
   (b) What laboratory examinations will help in the diagnosis?
5. (a) What conditions at present are considered to be due to an allergic reaction?
   (b) What means are available for determining the sensitizing agent?
6. Name the conditions which may show a membranous exudate on the tonsils or pharynx, and how would you differentiate them?
7. What may cause a unilateral edema of a lower extremity? How would you proceed to differentiate these possibilities?

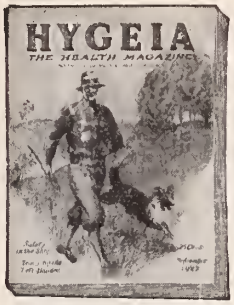
Answer any *five* of the above.

Pneumonia Complicated by Empyema

(Continued from page 919)

COMMENT

The birth of a normal although premature infant, under the circumstances, is worthy of note. I believe the drainage of the empyema in two stages was an important factor in her recovery. Very few instances of this type have been reported in either the English or French literature. A few cases were observed during the influenza epidemic in 1918, but most of them ended fatally with premature delivery. It is fair to assume, however, that similar cases are more common than the literature seems to indicate.



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Medical Course At least two years of college work, including English, foreign language, physics, chemistry and biology, are required for admission. The course requires at least four years for completion. During the first two of these years the work lies chiefly in the basal medical sciences outlined above. The third year of the course is devoted to didactic and practical instruction in the wards and out-patient department of the Wisconsin General Hospital. The fourth year of the course is devoted to practical instruction under the supervision of preceptors in the Wisconsin General Hospital and in affiliated institutions.

Courses in Nursing Courses in nursing are offered in the School of Nursing affiliated with the medical school. A residential course of 32 months is offered in the Wisconsin General Hospital to those who have completed a semester of specified work in the College of Letters and Science. This course leads to a certificate of graduate nurse. A residential course of 27 months is offered to those who have completed three years of college work in specified subjects either in the College of Letters and Science or in the Department of Home Economics. These courses lead to a certificate of graduate nurse and to a B. S. degree.

Graduate Courses Opportunity is offered for graduate work in the preclinical and the clinical medical sciences and in hygiene and public health. For further information address C. R. Bardeen, Dean, Medical School, Madison, Wis.

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Clinical Facilities Medical and surgical clinics are conducted in Milwaukee County Hospital, and in a number of city hospitals, thereby affording adequate facilities for imparting bedside instruction under scientifically competent and experienced staffs.

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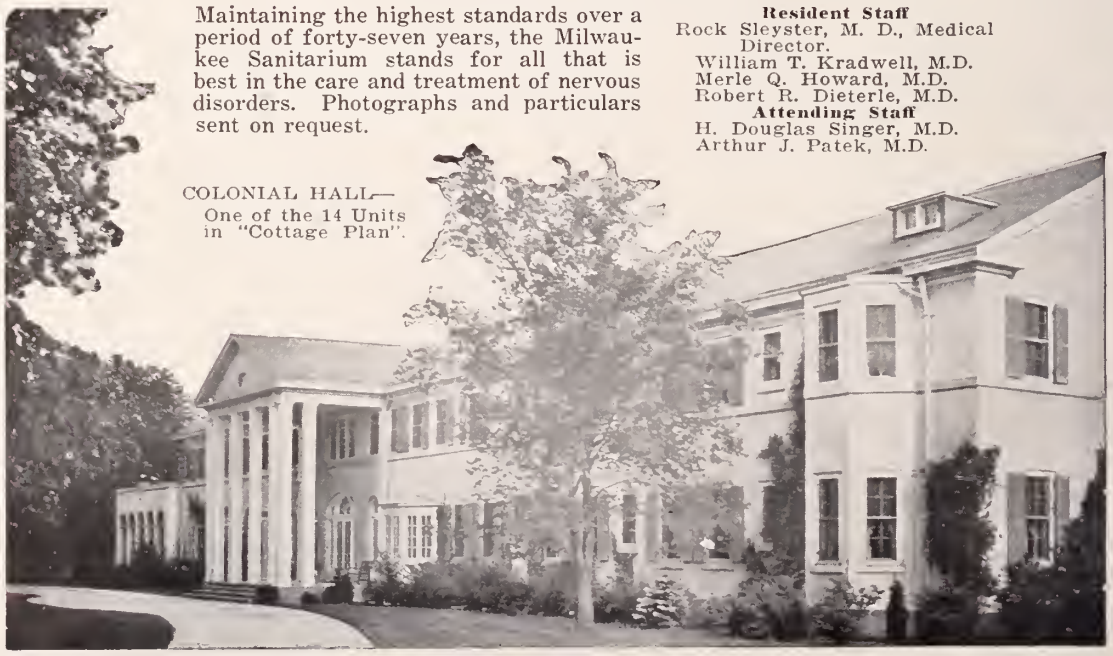

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STATE MEDICAL SOCIETY OF WISCONSIN — MEDICINA NUSQUAM NON EST

Owned and Published Monthly by the State Medical Society of Wisconsin
J. G. CROWNHART, Secretary-Managing Editor

VOLUME XXX
NUMBER 12

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MADISON, WISCONSIN, DECEMBER, 1931

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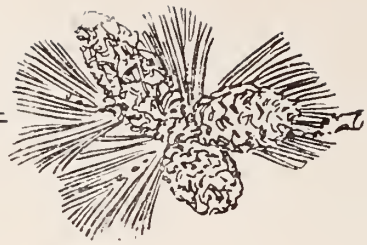

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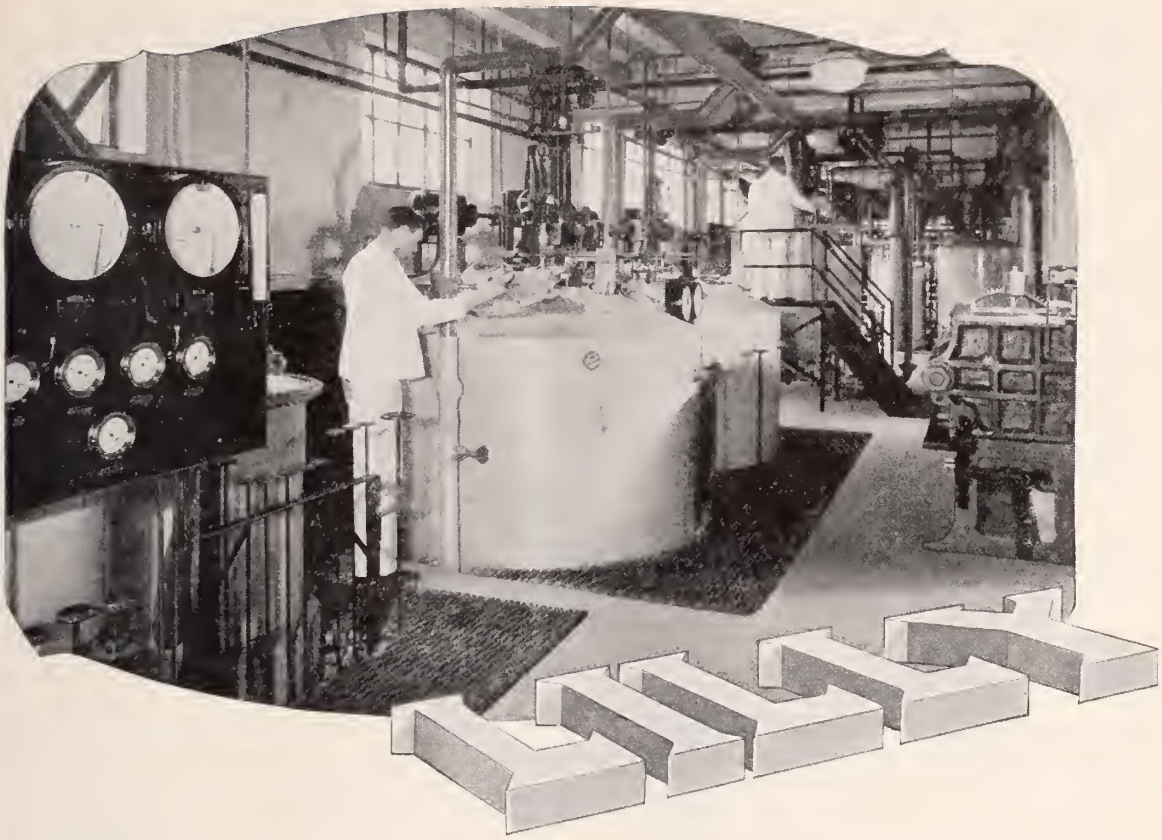

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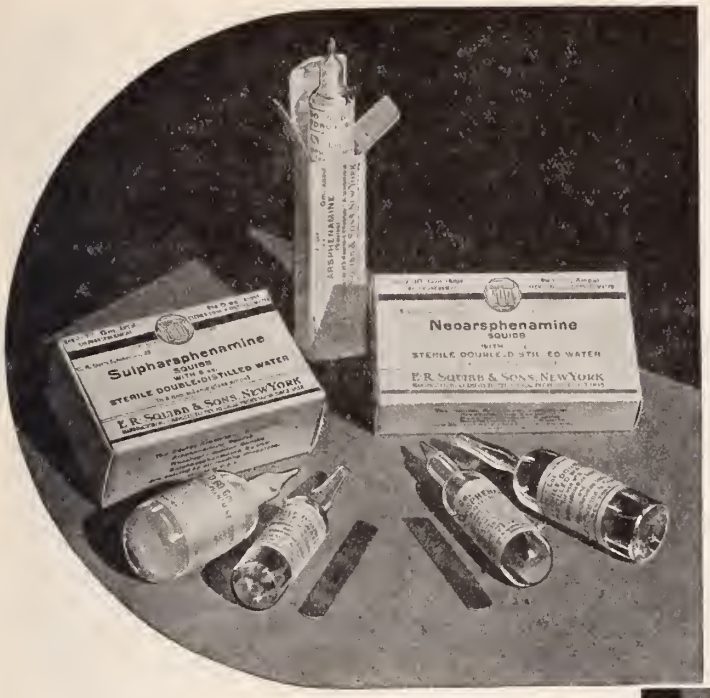

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Relative Values of Carbohydrates

New Findings Confirm Old Truths

Recent scientific investigations in rats (tabulated at the right) are in accord with many years of clinical observations on babies, as shown by the following excerpts from authoritative medical literature reflecting the consensus of three decades of pediatric experience.

RELATIVE ASSIMILATION VALUES OF VARIOUS CARBOHYDRATES[1]

		Average per 100 gms. body weight
1	MALTOSE	1.50
2	DEXTRIN + MALTOSE	1.32
3	Glucose + dextrin	1.32
4	Glucose + sucrose	1.32
5	Glucose	1.04
6	Sucrose + maltose	0.98
7	Fructose + glucose	0.98
8	Sucrose + dextrin	0.76
9	Sucrose	0.76
10	Fructose	0.5
11	Glucose + lactose	0.26
12	Lactose	0.16
13	Galactose	0.1

These authors have also stated: "Maltose, fructose, glucose, starch and dextrin *lead* in nutritive value, *followed by* galactose, mannose, arabinose, xylose, lactose, sucrose and glycogen.[2]

[1] H. Ariyama and K. Takahasi: *Biochem. Z.*, **216**:269 (1929) and [2] *J. Agr. Chem. Soc.*, Japan 5; 674 (1929).

CHART OF CARBOHYDRATE HYDROLYSIS[3]

MILK SUGAR GROUP
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Dextrose* — Galactose*

CANE SUGAR GROUP
Saccharose**
(Cane Sugar)
Dextrose* — Levulose*

MALT SUGAR GROUP
Starch
Amylodextrin***
Erythro-dextrin*** — Achro-dextrin***
Maltose**
Dextrose* — Dextrose*

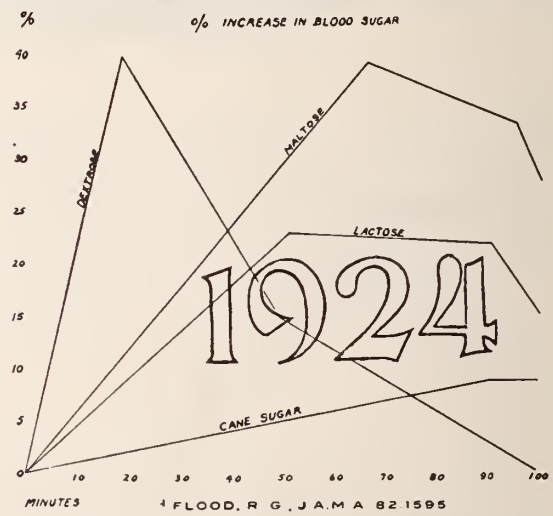
Note—The end product of maltose is all dextrose, which means quicker assimilation than end products from other carbohydrates.

*Monosaccharide **Disaccharide ***Polysaccharide

Of the monosaccharides, dextrose, the end product of maltose, is converted into glycogen more easily than levulose or galactose. Therefore, maltose, which splits into two molecules of dextrose, may be absorbed with much less digestive energy than either lactose or saccharose.

[3] Morse, J. L. & Talbot, F. B. *Boston Med. & Surg. Jl.*, **159**:852.

RATE OF SUGAR ABSORPTION IN NEWBORN[4]



[4] FLOOD, R. G. J.A.M.A. 82:1595

MALTOSE OR LACTOSE IN INFANT FEEDING[5]

Answer—The superiority of one form of carbohydrate over another in artificial feeding of infants has been much discussed during recent years. It is generally accepted that cow's milk without modification is not a satisfactory infant food. So far as the carbohydrate is concerned, about one-fifth to one-eighth ounce per pound of infant's body weight is required daily. To supply this amount it is necessary to add carbohydrates in some form. Admitting that lactose is the sugar supplied in human milk, it does not follow that it is the sugar best tolerated in another medium, such as cow's milk. It is generally believed that lactose is more laxative than sucrose—that it must be fed with a certain amount of caution, as fermentative upsets are likely to follow if amounts approximating that found in human milk are fed. There is cause for disagreement among clinicians, as it is important to consider the other food elements; i.e., the amounts of fat and protein fed as well as the medium in which they are fed. For example, when lactic acid milk is used, more added carbohydrate seems to be tolerated than when sweet milk mixtures are fed. Sucrose has the advantage of being much cheaper and is always available. Evidence has not been presented that it should not be used in infant feeding. With its general use in large infant welfare clinics where supervision is a matter of routine, there is less to be said against it as far as clinical results are concerned. The complaint that it is too sweet is not often encountered when the usual amounts are fed. The dextrin-maltose preparations possess certain advantages. When they are added to cow's milk mixtures, we have a combination of three forms of carbohydrates, lactose, dextrin and maltose, all having different reactions in the intestinal tract and different absorption rates. Because of the relatively slower conversion of dextrins to maltose and then to dextrose, fermentative processes are less likely to develop. Those preparations containing relatively more maltose are more laxative than those containing a higher percentage of dextrin (unless alkali salts such as potassium salts are added). It is common experience clinically that larger amounts of dextrin-maltose preparations may be fed as compared with the simple sugars. Obviously, when there is a lessened sugar tolerance such as occurs in many digestive disturbances, dextrin-maltose compounds may be used to advantage. [5] *Queries and Minor Notes, J. A. M. A.*, 88:266.

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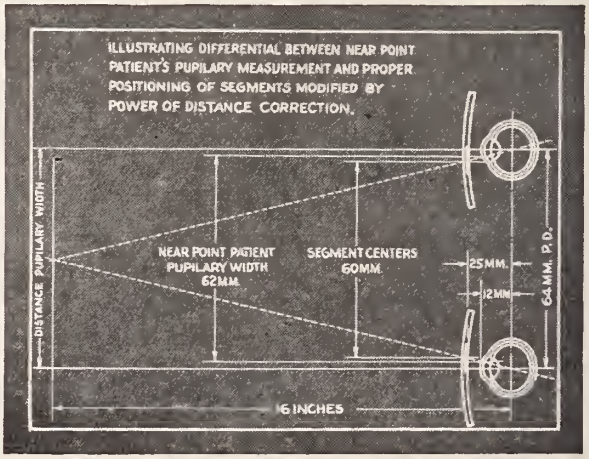

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2 teaspoons Knox Sparkling Gelatine	4.5	4	..	..	..
¼ cup cold water	..	..	..	..	..
½ cup hot water	..	..	..	..	..
½ teaspoon salt	..	..	..	..	..
¼ cup vinegar	..	..	..	..	..
1½ cups grated cheese	150	43	54	..	..
½ cup chopped stuffed olives	70	1	19	8	..
½ cup chopped celery	60	1	..	2	..
¼ cup chopped green pepper	25	..	..	1	..
⅓ cup cream, whipped	75	2	30	2	..
Total		51	103	13	1183
One serving		8.5	17	2	197

Soak gelatine in cold water. Bring hot water and salt to boil and dissolve gelatine in it. Add vinegar and set aside to chill. When nearly set, beat until frothy, fold in cheese, olives, celery, pepper and whipped cream. Turn into molds and chill until firm. Unmold on lettuce leaf and serve.

SPANISH CREAM *(Six Servings)*

	Grams	Prot.	Fat	Carb.	Cal.
1 tablespoon Knox Sparkling Gelatine	7	6	..	..	..
¼ cup cold water	..	..	..	..	..
1 cup milk	240	7	10	12	..
¾ cup boiling water	..	..	..	..	..
2 eggs	100	13	10.5	..	..
1½ teaspoons vanilla	..	..	..	..	..
Few grains salt	..	..	..	..	..
Total		26	20.5	12	336.5
One serving		4	3	2	56

Soak gelatine in cold water five minutes. Heat water and milk over boiling water, add gelatine and stir until dissolved. Separate eggs and beat yolks until lemon colored. Stir gelatine mixture slowly into egg yolks. Return to stove and cook over boiling water until mixture begins to thicken. Remove from stove, add vanilla and salt and chill. Beat egg whites until stiff and fold into jelly when almost set. Mold and chill until firm.

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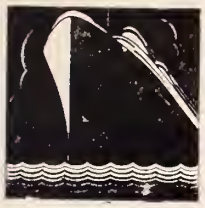

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The Wisconsin Medical Journal

Volume XXX DECEMBER, 1931 No. 12

The Treatment of Peptic Ulcer with Gastric Mucin*

By SAMUEL J. FOGELSON, M. D.
Department of Experimental Surgery
Northwestern University Medical School
Chicago

Although the direct etiology of "Peptic" ulcer in man has never been definitely established, almost all accepted types of treatment for these ulcers have had as their objective the reduction of the free acid in the stomach. The surgical treatment either attempts such an extensive resection that the remaining gastric fragment can produce little or no acid, or mixes the duodenal or jejunal contents so that in either case gastric acidity should be radically reduced. The most common medical treatment is based upon the addition of sufficient alkali to render the gastric contents either neutral or alkaline, thus combating the irritative action of the gastric juice. An ideal therapeutic agent for this purpose in peptic ulcer therapy should, however, neutralize or combine with the acid without materially stimulating or depressing gastric secretion, without materially affecting gastro-intestinal activity, and without having a general systemic action. Obviously with these prerequisites, none of the alkalies at present used in the treatment of ulcer can be classified as ideal.

While attempting to inhibit free acid secretion in Pavlov pouch dogs, it was observed that in practically every case when the free acid was very low, an excess of mucus was present in the gastric contents and conversely when the free acid increased, little or no mucus was present. This observation was so consistent that a study of the role of mucin in gastric physiology with especial reference to its antacid character was started.

In the literature on gastric secretion, the capacity of mucus to lower the free acid in the stomach is repeatedly suggested. In 1879, Heidenhein believed that mucus was alkaline and later Pavlov (1) suggested that it was the mucus which lowered the free acidity of the stomach by neutralization. Ivy (2) made pouches of the pyloric antrum in dogs and found the secretion of these pouches to be "mucoid, viscous, tenacious, transparent, odorless and slightly salty. It resembled egg white in appearance and consistency, was slightly alkaline with a pH of 7.0 to 7.5 and neutral to litmus." Lim, (3) in an exhaustive article on the relationship between gastric secretion and basal secretion of the stomach, states that: "it thus seems not unlikely that the colloid nature of mucus accounts (absorption of alkali) for the titrable total acid found with the lowest secretory rates." He adds that "at lower secretion rates the concentration of mucus is unquestionably higher especially in the case of entire stomach juice, containing pyloric secretion which is continuous and little altered by secretory activity in the fundus."

These physiologic observations suggested gastric mucus as an ideal antacid in that (a) it combines readily with the free acid, (b) it is a natural substance which plays normally a protective, soothing and lubricating role in the functioning of mucous membranes, and (c) its secretion or ingestion causes no chemical disturbances in the body and no unfavorable effect on gastro-intestinal secretory or motor activity. To evaluate gastric mucus as an antacid, it was necessary either to stimulate the secretion of mucus by the gastric glands or to administer it by mouth. Increasing the bivalent anions in the circulation should stimulate secretion from the gastric mucous glands (4) but in these experiments on Pavlov pouch dogs no definite effect was discovered.

* Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept. 1931.

The alternative procedure, then, was to prepare mucus from other sources and administer it orally to experimental animals and patients with the hope that the measurable free acid would in this way be definitely lowered and the lower secretion rates of Lim would be reproduced.

An ideal preparation of mucus would have the characteristics of the mucus that Ivy isolated in his experiments on the pyloric pouch. A mucin, resembling Ivy's very closely, was prepared by precipitation from a dilute hydrochloric acid solution of gastric mucosa at a pH of 4.5 after the addition of an equal volume of alcohol. When dried and neutralized to a pH of 7.0, it is mucoid, viscous, readily soluble in acid and alkali, faintly soluble in water and has a high combining power. One gram of this powdered mucin combines with about 15 cc. of 0.5 per cent hydrochloric acid.

On chemical analysis this powder was found to contain: moisture, 5 per cent; ash, 14.65 per cent; sodium chloride, 2.50 per cent; organic chlorine, none; total nitrogen, 9.93 per cent; phosphorus pentoxide, 4.45 per cent.

EXPERIMENTAL RESULTS

The mucin prepared from the hog's gastric mucosa and used in this experiment has a high combining power with free acid but does not depress gastric secretion. In fact, when equal quantities of this mucin in solution, egg albumin or gelatin, respectively, were put into the stomachs of Pavlov pouch dogs through a stomach tube, the mucin led to a slightly greater secretion of acid than either gelatin or egg albumin (Chart 1). It is well known that both egg albumin and gelatin are weak excitants of the gastric glands and for this reason they were contrasted to the mucin. Our results show that the mucin as prepared at present is only a mild gastric secretory excitant. These experimental results have been confirmed by Drs. Ivy and Kim, who report the following from the hog gastric mucin with which I supplied them. "(1) The hog's gastric mucin used has a high combining power (1 Gm. combining with from 12 to 15 cc. of tenth normal hydrochloric acid); (2) it does not

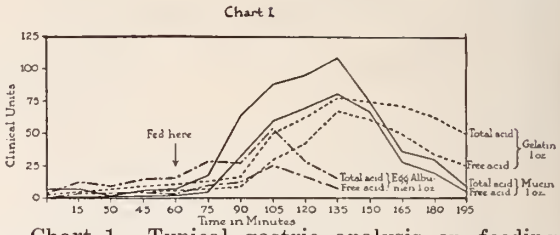

Chart 1.—Typical gastric analysis on feeding dogs 1 ounce of mucin, gelatin and egg albumin. From the free and total acid values shown here it is obvious that mucin as at present prepared is a slightly greater gastric stimulant than either egg albumin or gelatin.

irritate the gastro-intestinal mucosa; (3) it mildly stimulates the gastric glands and in its present form it excites the gastric glands on being perfused through a pouch of the entire stomach, which proves that it contains secretogogues."

When two (2) ounces of mucin, egg albumin, gelatin or meat, respectively, were introduced by stomach tube into the stomach of the Pavlov pouch dogs and the dogs were excited to secrete gastric juice at the beginning of the experiments by an adequate dose of histamine, it was noted that there was complete absence of free hydrochloric acid only in the stomachs containing the mucin, whereas the Pavlov pouch in all cases secreted the usual free acid. These results (chart 2) show that the mucin has a high combining power with free acid in vivo. Chart 3 shows a comparison of the free acid in the stomach when immediately after histamine stimulation 2 ounces of mucin, gelatin, or egg albumin and 4 ounces of meat, respectively, were put into the stomachs of Pavlov pouch dogs.

Of further interest were the results obtained from feeding Pavlov pouch dogs a pound of meat in which there was mixed half an ounce of powdered mucin. Meat itself, of course, has a high combining power,

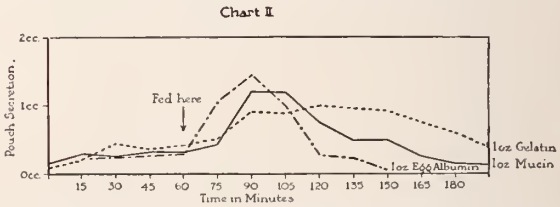

Chart 2.—This chart supplements chart 1 and demonstrates that our preparation of mucin, put into the stomachs of Pavlov pouch dogs, will lead to about the same quantity of "pouch" secretion as gelatin or egg albumin.

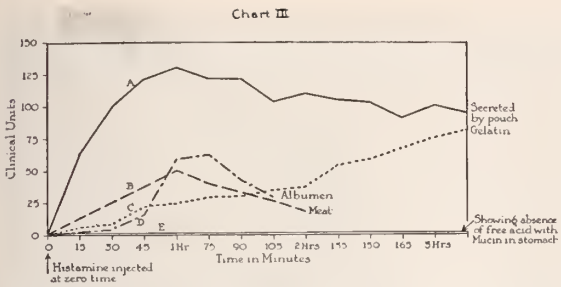

Chart 3.—Demonstrating that after adequate stimulation by histamine as shown by the pouch secretion, only mucin will keep the free acid in the stomach at zero. Only the free acid values are plotted in the chart; *A* is free acid value of the pouch secretion; *B* is free acid value of gastric contents with 4 ounces of meat in the stomach; *C* is free acid values of gastric contents with 2 ounces of gelatin in the stomach; *D* is free acid values of gastric contents with 2 ounces of egg albumin in the stomach; *E* shows absence of free acid with 2 ounces of mucin in the stomach.

but in the controls that were fed meat alone some free acid was present in these dogs' stomachs throughout an observation period of from five to seven hours or until the stomachs were empty. But this free acid was absent in all cases when the half ounce of mucin was added to the meat; this was especially significant as the pouches in all trials showed the expected stimulation (chart 4).

Encouraged by these results in animal experiments and because I was able to obtain a preparation of mucin free from intestinal parasites, ova and other objectionable features, I extended the experiments to cases of peptic ulcer in man.

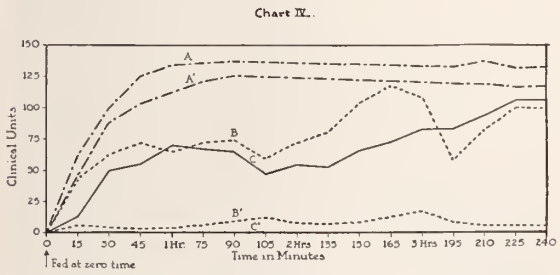

Chart 4.—This contrasts feeding Pavlov pouch dogs a pound of meat alone with a pound of meat mixed with half an ounce of mucin. There is no free acid in the stomach when the mucin is added, as shown by curve *C'*. *A*, total acid value of pouch secretion; *A'*, free acid value of pouch secretion; *B*, total acid value of gastric contents with meat feeding; *B'*, free acid value gastric contents with meat feeding; *C*, total acid value of gastric contents with meat plus mucin feeding; *C'*, absence of free acid in gastric contents with meat plus mucin feeding.

CLINICAL RESULTS

In 1930, there were 34 patients with typical ulcer history available for study. Four of these had had a gastro-enterostomy and now had the subjective and objective findings which indicated gastro-jejunal ulcers. Two had the surgery limited to the duodenum and were acutely ill when the mucin treatment was instituted. Two were diagnosed ulcers of the duodenum for the first time and the remaining 26 had been treated over ninety times with the usual alkalinization and diet without persistence of relief; sixteen of these twenty-six had been invalided from two to six months in 1929, and the symptoms had been present from two to seven years.

In the first six months of 1931, there were available for study another group of 34 cases. Six of these had had a previous gastro-enterostomy, two had a duodenal perforation sutured and one a Billroth I. Only two of this group were diagnosed ulcer of the duodenum for the first time and in the other thirty-two a diagnosis of ulcer of the duodenum had been made and symptoms present from two to twenty years before mucin therapy was started.

The general procedure was to give about 100 grams of powdered mucin per day. Half an ounce was given at 10:00 A. M., 2:00 P. M., 4:00 P. M., 8:00 P. M., 10:00 P. M., and in addition, 15–30 grains of mucin were given in capsules on the hours when the large doses were not given. In the very severe cases, 10 grams of mucin were given hourly until the acute symptoms subsided. The diet consisted of the usual bland convalescent ulcer diet, being practically the Alvarez ulcer diet. All the vitamines were included in liberal quantities. (Table I)

In thirty-three of the 1930 cases, the subjective symptoms disappeared within three days of treatment, the most gratifying feature being the persistent absence of pain, the gain in weight and the increase of hemoglobin and red blood cells. As yet there has been no recurrence in this group, although one of the worst cases had a very severe attack of Ludwig's angina. The one failure in this group did not respond to mucin therapy despite rigid adherence to the prescribed

routine and has been lost for further observation.

The relief of subjective symptoms in the 1931 group has been just as dramatic, there being one questionable failure in the case which had the Billroth I. This patient had an excellent response for six weeks only to have a recurrence of pain, which is believed due to his being treated by error with mucin which had spoiled in manufacture. The most gratifying feature of this group has been the excellent response of the patients with the gastro-enterostomies. All of these have been rendered symptom free and restored to complete economic fitness.

TABLE I

	Group I Jan.-June 1930	Group II July-Dec. 1930	Group III Jan.-June 1931
No. of cases	24	10	34
Prev. operat.	1 resection 1 G. E. 1 pyloroplasty	1 G. E. 1 suture of perforation	6 G. E. 2 sut. perfor. 1 Billroth I
Failures	1	0	1 (?)
Av. wgt. gain	15 lbs.	12 lbs.	12 lbs.
Av. inc. R. B. C...	750,000	650,000	500,000
G. J. ulcers	2	1	5

COMMENT

It is realized that periods of observation varying from three to twenty months cannot justify any thought of cure in this small series of sixty-eight cases. But since mucin, from a theoretical and experimental point of view, proves to be practically ideal, an extensive clinical trial is indicated. The mechanism that afforded the relief from symptoms may be the combination of the free hydrochloric acid with the mucin, although another important factor is present that cannot be ignored. J. E. Whitlow, (5) studying the protective role of gastric mucus against the proteolytic action of gastric secretion, concluded:

1. Gastric mucus does delay and inhibit—though not prevent—the diffusion of hydrochloric acid and pepsin.

2. The rate of diffusion of hydrochloric acid through gastric mucus is inversely proportional to the depth of mucous layer and inversely proportional to increase in viscosity of the mucus; the diffusion of pepsin is directly proportional to the time required for the hydrochloric acid to diffuse through the entire depth of the mucous layer.

3. The presence of tenth normal hydrochloric acid in gastric mucus hastens the rate of diffusion of pepsin through a layer of mucus.

Fig. 1. Showing markedly deformed duodenal bulb in case of duodenal ulcer of over 10 years duration.

4. The fact that gastric mucus covers the mucous membrane of the stomach with a viscid, tenacious coat that retards digestion and diffusion of gastric juice as shown by in vitro experiments makes it impossible to deny the protective role of this secretion against autodigestion of the stomach.

5. The most direct evidence of all, however, is the fact that when the mucus is wiped away with a cotton swab and tenth normal hydrochloric acid or normal gastric juice is applied, bleeding occurs, and when merely swabbed with equal vigor and mechanical irritation, no bleeding occurs. It becomes a self evident fact, therefore, that mucus protects the gastric mucosa against the action of gastric juice.

Similar results are reported by Klug (6) and it is highly probable that the relief from symptoms obtained from feeding the mucin preparation was secondary to two factors. First, the mucin coated the ulcer and protected it against the proteolytic action of the gastric secretion, and second, through its high combining power with free acid it united with enough hydrochloric acid not only to neutralize the corrosive action of gastric juice but also to prolong the rate of dialysis of pepsin through the now present

Fig. 1a. Showing duodenal bulb of same patient as in Fig. 1 with duodenal bulb remarkedly improved after six months of duodenal therapy.

protective mucin layer. Obviously, both these factors would be important in affording relief from pain and in hastening healing.

Fig. 2. Showing jejunal loop in case of ulcer recurrence 18 months after gastroenterostomy. Note marked narrowing of bowel and excavation defect. Patient acutely ill.

SUMMARY

1. Gastric mucin prepared from hog's stomach is only a mild excitant of gastric secretion.

Fig. 2a. Showing jejunum of patient shown in Fig. 2 after 3 months of mucin treatment. Note the return of bowel lumen to normal and practically complete disappearance of defect. Patient now symptom free.

2. Gastric mucin has a high combining power. Two ounces of mucin placed in the stomach of the dog was more than sufficient to combine with the acid secreted in response to the injection of 1 mg. of histamine.

3. When half an ounce of mucin was mixed with a pound of meat and fed to a dog, free acid did not appear in the dog's stomach throughout the period of observation of from five to seven hours.

4. Complete relief from symptoms for varying periods of from three to twenty months and complete restoration to economic fitness was afforded to sixty-six out of sixty-eight patients with classic ulcer histories and roentgen findings of peptic ulcer by feeding them about 100 grams of powdered neutral gastric mucin obtained from hog gastric mucosa. As a rule, half an ounce was given at 10:00 A. M., 2:00 P. M., 4:00 P. M., 8:00 P. M., and at 10:00 P. M. and in addition, from fifteen to thirty grains of mucin in capsules on the hours when the large doses were not given.

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The Indications for Surgery in Peptic Ulcer*

By CARL S. WILLIAMSON, M. D.
Green Bay

That the surgical treatment of peptic ulcer has left much to be desired in the final analysis of those cases so treated is shown by the acrimonious discussions appearing in the medical literature. But that surgical treatment in properly selected cases of peptic ulcer is invaluable cannot be denied, and it has seemed to me that in these discussions the choice of operative procedures has been unduly stressed, while the indications for surgical intervention have been almost entirely neglected.

It used to be jokingly said that a peptic ulcer became surgical in nature after half a dozen or more medical cures. Such a statement was made undoubtedly because of the tendency of the lesion to recur after medical management. But that it also recurs after surgical treatment has become widely known due to accurate follow-up records of our patients. The result is that in a search for the cause of this recurrent trouble, the surgeon has been inclined to blame his plan of attack rather than the nature of the lesion and its etiological factors for the poor results following operation.

Peptic ulcer is in the vast majority of cases a chronic lesion located in the stomach or duodenum, characterized by periodic or seasonal exacerbations of symptoms. The exact etiology of the lesion is unknown, although infection, hyperacidity and temperament are predisposing factors. There is a tendency for the lesion to produce perforation, pyloric obstruction and hemorrhage. The first two conditions make surgical intervention imperative, and the results are usually satisfactory, especially in the cases of pyloric obstruction. Hemorrhage may at times become so severe that surgical control must be attempted in an effort to control the bleeding. There is still another group of patients in whom pain is so severe that it cannot be controlled by medical management. In these cases, early operative interference is indicated. All told, this group of ulcer cases, that is, those in which there is perforation, obstruction, hemorrhage or uncontrollable pain, comprise only about ten to fifteen per cent of the total number of cases. These are the cases in which some type of operative interference must be undertaken without de-

* From the section of surgery, Green Bay Clinic, Green Bay, Wisconsin. Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept. 1931.

lay, and strange to say, these are the cases, with the exception of the perforating and the hemorrhagic group, that give a high percentage of satisfactory end results.

The ulcers which are located in the duodenum are practically always benign in character, but that the lesions in the stomach not infrequently become malignant is an accepted fact. The frequency with which malignant changes are found in an ulcer in the stomach has been a mooted question for the past decade, and seems little nearer solution now than it did ten years ago. Certainly when the treatment of a peptic ulcer in the stomach is being outlined, the possibility of a malignant change should always be considered. It matters little from the treatment standpoint if an ulcer in the stomach has been malignant from the onset, or if it was a benign ulcer in the beginning and has subsequently undergone malignant degeneration. There are no diagnostic methods available at the present time that are sufficiently refined to detect these early malignant changes preoperatively. Therefore, it seems to me that the diagnosis of an ulcer in the stomach should warn the attending physician of a possible malignancy, and if the response to medical management is not prompt, and complete, surgical intervention should be undertaken without delay. It is far better to be too radical in a number of these cases than to be too conservative and sacrifice the life of the patient to a cancer of the stomach. Prolonged medical management in a case of ulcer in the stomach of a patient in the cancer age is, in my opinion, never justifiable, until we have at our disposal some means of distinguishing the ulcer of malignancy from the simple benign ulcer.

Because of the unknown etiology of peptic ulcer, any operation that is performed for the relief of the condition must relieve the distress and promote healing only. It does not remove the exciting cause of the lesion. Hence, the re-development of symptoms following any method of treatment must be anticipated in some instances. It is upon this basis of reasoning that the advocates of gastric resection base their premise. They believe that hyperacidity, being one of the important exciting causes of peptic ulcer, the removal of the acid-bearing portion of the stomach should be the treatment of choice. Some of the results following this type of treatment have been remarkable, but like the more conservative operations, the results leave much to be desired in some instances.

Another factor that may prove of some importance in the treatment of peptic ulcer is the nationality of the patient. The German and Austrian lesions seem much more refractory to treatment than do those of the English. In this country the peptic ulcers of the East coast are more stubborn in response to treatment than are those of the Middle West and Western portion of the country. The economic struggle for a livelihood may or may not be a basis for this difference. Certain it is that many observers have called attention to the frequency with which peptic ulcer attacks persons of a high tension type of personality.

DUODENAL ULCERS

It is in the large group of ulcer cases in which the lesion is located in the duodenum and in whom elective surgery is performed that the results are poorest. The selection of ulcer cases from this group for operative interference should only be done after a careful study of the case by both the surgeon and the internist. These are cases in which serious complications endangering life are relatively infrequent, and the lesion has in most instances been present for a long period of time. Why then, should surgery be undertaken without adequate study of the case? I believe that we, as surgeons, have been over anxious to interfere in what should be regarded as a medical case. That many of these cases recover spontaneously is amply shown at the autopsy table where many old healed ulcers are discovered, and that many others respond to adequate medical management cannot be denied. Hartman has recently published the results of a study of one hundred cases of ulcer of the duodenum in physicians in which medical treatment was employed. In ten per cent of these cases, complications developed, making surgical intervention necessary, and in another ten per cent the results were not satisfactory so that later surgical interference was neces-

sary. The remaining eighty per cent of the cases obtained complete relief from symptoms and were regarded as cured. This series of cases compares quite favorably with that reported by Balfour who gave his end results in one hundred cases of ulcer of the duodenum in physicians treated by operation. He found ninety per cent were relieved.

I believe that we are rarely justified in operating upon an ulcer of the duodenum in the elective group, about eighty-five per cent of the total group, until a thorough attempt has been made to relieve the symptoms by adequate medical management. This management should be had under the supervision of a well trained internist, unless the surgeon has at his disposal sufficient leisure to follow the case in minute detail, a thing that time and training does not permit for the most of us. The chronic nature of the lesion, the absence of malignancy and its tendency to recurrence, should be explained to the patient and his cooperation assured before instituting treatment. A non-cooperative patient with a poor result will otherwise be our reward. The medical management of a case of peptic ulcer is trying at times for both the patient and the physician, but if the patient is unwilling to cooperate before operation, it is unlikely that his cooperation will be improved by it. In fact, the vast majority of patients upon whom an operation has been performed are reluctant about being placed upon a strict dietary regime unless they are made to understand beforehand that this is a part of their treatment just as much as was the operation.

The imposition of a sane dietary and hygenic regime upon the patient suffering from an ulcer is not necessarily a hardship. It implies first of all the removal of all possible foci of infection, and here let me insist that this be done preferably before the institution of any treatment for the ulcer, be it medical or sugical. Never, except in the very acute lesions are we justified in delaying this important preliminary work. It is very easy for the patient when his pain is better to forget to have his infected mouth cleaned, his tonsils removed or to come for prostatic massage when the pain in his stomach is better. For the severe cases of ulcer, hospitalization may be required for a week or ten days, but we have found in our clinic that the vast majority of cases can be placed upon an ambulatory type of treatment with good results. The patients are given a list of foods with definite times for food and medicines indicated. They report to the clinic every week or ten days and any corrections in diet are discussed. The majority of the patients are able to continue with their occupations from the beginning of treatment and within two to three weeks are upon an adequate diet and practically free from symptoms.

Unquestionably the close cooperation between the surgeon and the internist preoperatively and post-operatively will do much to improve the prognosis in ulcer of the duodenum.

While ulcer in the stomach and duodenum have so far as we know a common etiological factor or factors, and in many respects run a similar course, the management of the lesion in the two locations is of necessity dissimilar. Ulcer in the stomach not infrequently occurs in conjunction with ulcer of the duodenum. But the incidence of the lesion in the duodenum is much greater than in the stomach. The same medical treatment is applied to the lesion whether it be located in the stomach or the duodenum. But very unlike the lesion in the stomach the duodenal lesion practically never becomes malignant. It is this difference in character which leads me to feel that ucler of the duodenum, except when complicated by perforation, pyloric obstruction, hemorrhage threatening life or pain so severe that it cannot be controlled by medical management, should be given the benefit of medical treatment in all cases before resorting to surgical intervention. Ulcer in the stomach on the other hand is subject to the same complications as the duodenal lesion, and the possible malignant changes in addition. Therefore, we are rarely justified in prolonged medical treatment of these cases for fear that we are mistaking a malignant ulcer for a benign one or that a benign ulcer has undergone a malignant change. And until we have at our disposal diagnostic methods which en-

able us to detect these changes without resorting to biopsy, we must continue to regard all ulcers of the stomach as being surgical lesions without undue delay.

SUMMARY

I. The complications of peptic ulcer such as perforation, pyloric obstruction, hemorrhage and intraceable pain make immediate surgery imperative.

II. Elective surgical interference in ulcer of the duodenum is not justified until thorough medical treatment has been tried.

III. Prolonged medical treatment of ulcer of the stomach is not justified because of the difficulty of differentiating a benign from a malignant ulcer.

IV. The cooperation of the surgeon and the internist in all cases of peptic ulcer will do much to lessen the number of ulcer cases requiring surgical treatment, and improve the final results in those cases so treated.

Intravenous Urography; Its Place in Urology and General Practice*

By HARTWICK M. STANG, M. D.
Eau Claire

Visualization of the urinary tract is now possible in two ways: first, through instrumental means, that is retrograde by means of ureteral catheters and the cystoscope, and second, by employing the function of the kidney to eliminate physiologically an opaque substance in the urinary tract. The opaque substance can be administered either by mouth, rectum, or intravenously. Administration by mouth and rectum as yet has not been successful.

Retrograde visualization has been in practice since Von Lichtenberg and Völcher produced their first practical pyelograms with the colloidal heavy metals in 1905 and 1906; intravenous visualization only since 1929. However in 1923 Rowntree and his associates using large doses of sodium iodide intravenously proved conclusively that intravenous urography was possible. Iodine in its free form was poorly tolerated by some of the patients and the procedure was discontinued. Research continued in this country and in Europe. Roseno described a substance of combined iodine with urea. This was the first solution which placed this method on a clinical basis. Again certain patients were sensitive to the substance and farther investigation was necessary.

Binz and Raeth of Berlin had discovered "selectan neutral" a combination of pyridine with iodine which was being used intravenously as a urinary antiseptic. Hryntschak in 1927 employed it in animals and clearly visualized the urinary tract. Swick, a fellow on the Libman foundation working in Von Lichtenberg's Clinic, recognized early in 1929 the value of this group. Under the guidance of Von Lichtenberg and Swick, Binz modified the drug until it was relatively non-toxic. A substance was produced that was excreted by the kidneys in sufficient concentration to cast a radiographic shadow thereby visualizing the urinary tract. It was called "uroselectan."

Intravenous urography is no doubt one of the important accomplishments of this decade in urology. It may well be placed on a parity with the advancements made through the developments of cystoscopy, x-ray, and instrumental pyelography.

There are three solutions available clinically at the present time.

1. Uroselectan, now called iopax and a modification of this neo-iopax—a sodium salt of pyridine derivative with 42 per cent organically combined iodine. (Sodium 2 oxy.—5 indopyridine—N—acetate).

2. Skiodan—(a mono-iodo-methane sulphurate of sodium) an organic salt containing 52 per cent iodine so strongly combined it will not react with stronger acids like nitric or hydrochloric.

3. Abrodil (ICH_2SO_2Na) a sodium salt of iodomethane sulphuric acid containing 52

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per cent iodine soluble in water up to 70 per cent room temperature.

Skiodan is the most popular at the present time probably due to its easier preparation and greater concentration. Both skiodan and neo-iopax are now on the market in solution and in sterile ampules ready for use. Abrodil is a newer preparation and in this country has not been used clinically so extensively.

This newer method of urography has given us important information in three ways: (1) the visualization of the urinary tract physiologically has added to our knowledge of the relationships of the various parts of that system; (2) important factors concerning kidney function by roentgenological means have been added to those already known; (3) the dynamics of the urinary tract can now be better observed.

The contra-indications to the intravenous procedure are relatively few. Caution must be exerted in; (1) severe renal and hepatic insufficiency, (2) active pulmonary tuberculosis, (3) thyrotoxicosis, (4) children with exudative diathesis.

The reactions experienced during the injection of the different solutions are various. They are far less severe with neo-iopax, skiodan, abrodil than with uroselectan. These reactions are warmth, dryness of throat and mouth, uneasiness, choking, palpitation, syncope, nausea, vomiting, tachycardia, pain at the site of injection extending up to the shoulder, acute pain in the kidneys radiating down to the bladder (undoubtedly caused by the sudden stimulation of the excretory apparatus in the glomeruli), urticaria, sneezing, and lacrimation. The majority of the symptoms experienced are not all present in the same individual and they vary in intensity.

TECHNICAL PROCEDURES

It is unnecessary to give dosages, preparation, and manner of injection. Instructions are present with the solutions and surely all are familiar with ordinary methods of asepsis an intravenous procedure. X-ray films are taken before injection and at intervals of 5 minutes, 15 minutes, and 45 minutes after injection. At times it is necessary to take exposures at longer intervals especially where kidney function is impaired and delayed, or where there is a large hydronephrosis and considerable quantity of excretion of the dye is necessary to produce visualization. Practically 90 per cent of the dye is excreted in one hour and can be recovered in the urine chemically. These various drugs are as near the ideal as possible for retrograde urography. They are non-irritating to the urinary tract and the attacks of pain are absent which occasionally follow ordinary pyelography with sodium iodide and bromide.

INDICATIONS FOR USE

Intravenous urography has its greatest value in determining conditions in cases: (1) where anatomical and pathological or technical reasons preclude cystoscopy, ureteral catheterization, or instrumental pyelography; (2) where ureteral obstruction prevents injection of the solution beyond point of obstruction; (3) where instrumental investigation becomes a risk to the patient; (4) where clinical evidence assures that intravenous urography is sufficient; (5) in children (to determine if instrumental investigation is necessary); and (6) in that class of intolerant individuals who refuse cystoscopy and it is wise not to cystoscope.

Enumerating some of these conditions more specifically we have: (1) anatomical obstruction of the ureter or urethra where it is impossible to pass a catheter or cystoscope; (2) investigation of the urinary tract after surgical procedures, as transplanting ureters into colon, nephrectomy, or plastic operation on kidney or bladder; (3) determination of anomalies in urinary tract such as fused and solitary kidney, duplicated ureters, ectopic kidney, ptosis and polycystic kidneys; (4) strictures of ureter or urethra; (5) calculi either in bladder, ureter or kidney; especially valuable if stone is producing obstruction in ureter; (6) contracted bladder from tuberculosis, or other inflammatory conditions which prevent thorough cystoscopic examination; (7) prostatic obstruction, (it is a marked aid in determining function of kidneys and visualizing upper urinary tract and is a great assistance in fol-

low up of a prostatectomy); (8) some assistance in renal tuberculosis, especially since many authors consider it inadvisable to do bilateral pyelography (plenty of opportunity for error in these cases); (9) in extensive tumors of bladder which conceal ureteral openings; (10) in marked hematuria and edema of bladder concealing ureters; (11) diverticulosis of bladder, especially where ureter opens into one of them and difficult to find or catheterize; (12) hydronephrosis (caution in interpretation necessary because this condition is intermittent and pelvis may be empty at time of examination); (13) where bilateral pyelography is desired; (14) traumatic injuries to kidney or bladder; (15) intolerant and nervous individuals; (16) often in children definite information is found eliminating instrumental investigation; (17) test for function of kidneys, (expensive).

With the introduction of uroselectan the statement was once made that the art of cystoscopy and ureteral visualization would become as obsolete as laryngeal intubation and other similar procedures of the remote past, that it would become a roentgenologic procedure. This statement was not based on facts or experience. Most errors have been made in the diagnosis and treatment of urological conditions because there was not the proper cooperation between the roentgenologist on the physical side and the urologist on the clinical side. Grave dangers exist for the patient in this new situation with an easy method of administration and interpretation so difficult. Needless surgical procedures are being taken on insuffcient grounds. On the other hand, early diagnosis and necessary surgical measures are being denied because of faulty and inadequate examinations.

Intravenous urography can never designate accurately where pus and blood comes from in the urinary tract. Endoscopy, cystoscopy, and catheterization of the ureters can only segregate this condition. Acute inflammations cannot be visualized. Renal tuberculosis and tumors in their early stages can be located by intravenous urography in very few instances, and these conditions are most important for early diagnosis as far as the patient is concerned. Visualization of the lower urinary tract with intravenous urography is of benefit in less than 50 per cent of the cases. Nothing can take the place of actual visualization in the urethra and bladder by cystoscopy. Retrograde pyelography, where possible, far exceeds intravenous in distinctness of outline and richness in detail. However it is a mechanical investigation rather than a physiological one and must be performed skillfully. Negative intravenous urographic x-ray films are not worth anything when positive clinical findings are present.

This type of procedure then becomes a wonderful complement to cystoscopy and the urologist and is an adjunct to the older method of examination. It is a functional process and compares to the colon examination with barium and the dye in cholecystography. Interpretation is difficult. No part of the kidney pelvis and ureter is completely filled at one time. Only a relative interpretation can be made in a large number of cases. The kidney may be in either systole or diastole at the time of exposure and then only a series of plates, rapidly taken at few seconds intervals, or pyeloscopy, will show the true conditions. (This will be the next step in urography.) Practically all patients in urological clinics are cystoscoped at the present time either before or after the intravenous iodine solution has been given, especially where accuracy of diagnosis is desired. No one absolutely feels sure of his ground. Eventually this form of investigation will become stabilized. Experience will increase its value and solve many problems. As yet it is not a routine office procedure.

SUMMARY

Intravenous urography is the greatest contribution to urology in the last decade. It is a wonderful complement to cystoscopic procedures. Its true value has not been reached. Further research both clinical and laboratory will be made and finally many problems will be solved for both the roentgenologist and urologist as well as the patient in urinary tract pathology and suspected lesions.

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Osteomyelitis; A Study of 162 Cases Treated by the Orr Method*

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In 1923 Orr described a method for the treatment of osteomyelitis which has since been known by his name. It was immediately adopted by Dr. Gaenslen, on the orthopedic service, and has been used routinely since.

The hospital records show that two hundred and five patients have been admitted on whom a diagnosis of osteomyelitis was made. Of these, forty-three are not included in this report because:

17 were discharged without treatment.
16 were treated on services other than the orthopedic, and in them osteomyelitis constituted a secondary complaint.
7 patients refused treatment.
2 were inoperable.
1 was a re-amputation.

This paper is based on a study of the remaining one hundred and sixty-two cases. Its purpose is to present the end results of treatment rather than to go into detail regarding the method itself. It is based on the principle of drainage, the removal of dead tissue, and rest for the diseased part.

We have used Orr's method with some modifications. A generous incision is made. The soft tissue is reflected in one mass, but no more so than is necessary in dealing with the underlying diseased area. The bone is saucerized, permitting abscess evacuation or removal of sequestra, but allowing no bony overhanging edges.

If a sequestrum is present, the overlying bone is completely removed before any attempt is made to pull out dead bone. Premature attempts to remove sequestra often cause them to break; fragments remain incarcerated by overlying healthy bone, and continued drainage is the result. The bone defect is then saucerized. By this is meant the removal of overhanging bone edges. It insures the healing of bone defects from the bottom. Next, the wound space is dried. Wherever possible, our cases have been done under tourniquet. The cavity is packed

* Presented before 90th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept. 1931.

with vaseline, and a plaster of Paris cast is applied. The vaseline serves as a drain and keeps the wound open until granulation has filled it from the bottom. Odor is the chief indication for changing the cast which is done at intervals until the wound healing is complete.

By those unacquainted with the method, objections are sometimes made as follows: first—that the vaseline serves as a plug and so prevents the escape of pus from the wound; second—that the cast is unnecessary, hinders wound inspection, antiseptic wound irrigation, causes stiff joints, and finally, that retention of pus by the cast causes offensive odor.

The answer to the first objection is that pus escapes between the vaseline and the granulation wall of the wound.

As to the second, Orr is emphatic in his denunciation of meddlesome interference with the wound. He cuts no windows in the cast for wound inspection. He decries the antiseptic irrigation of wounds, says that it does more harm than good, and promotes secondary infection.

Plaster of Paris does not cause joint stiffness. It need not be feared unless there has been joint involvement. Moreover, it prevents joint deformity.

Finally, the odor of the cast is of less importance than might be supposed. It does the patient no harm. It should be explained to him that it is to be expected.

The one hundred and sixty-two cases included in this study have been divided into two classes—haematogenous, of which there were one hundred and thirty one; and non-haematogenous, of which there were thirty-one. Twenty-three of the non-haematogenous group were the result of fractures.

Of the one hundred and thirty-one haematogenous cases, nine were admitted to the hospital as acute. Four of them died—two from septicaemia, soon after onset; two died later, one from sepsis, and one from amyloid disease. The death rate emphasizes how seriously the disease menaces the life of the patient. The number of acute cases is small because ordinarily cases are not sent into the hospital while still acute.

Of the remaining five acute cases, three were operated on early and did not require later radical operation for removal of dead bone. Usually the extent of bone destruction is directly proportional to the time interval between the onset of the disease and adequate drainage.

Among one hundred and twenty-two cases of chronic haematogenous osteomyelitis, twenty-one, or seventeen percent, had spontaneous evacuation of pus prior to incision; forty-six cases, about thirty-seven and five tenths percent, were correctly diagnosed at the onset; in forty cases, thirty-three percent, the diagnosis was incorrect; in fourteen cases, eleven percent, the diagnosis was not made; and in thirty-one cases, twenty-five percent, it was not recorded in the history. It is here that the greatest improvement in treatment may be sought for, namely, early diagnosis. Rheumatism, a diagnosis by expectation, occupies too prominent a place in the minds of physicians attending sick children with painful extremities.

Seventy-three of the one hundred and twenty-two chronic cases had had one hundred and nineteen operations performed prior to arrival at the hospital; ninety-two were admitted with draining sinuses; eighty-six had sequestra as shown by x-ray; sixty-four, or almost half, had deformities, and thirty-one cases, or twenty-five percent, had joint involvement on admission. These figures give some idea of the type of cases admitted to the hospital.

The outlook as to function in joint involvement is bad. Of four cases with tarsal involvement, one had a leg amputation; three were treated by Gaenslen's method in which the os calcis is split to remove sequestra in that bone. They are healed and have functionally useful feet.

Of eight cases of septic arthritis of the knee, only one has a functionally useful joint. In this case, extension of pus into the knee joint occurred while the patient was in the hospital. It was treated by Willems' method. One patient had a sequestrectomy, and because of ruined joint surfaces and draining sinuses, six patients had an arthrodesis.

Of sixteen septic hip joints, all have functional disability. This also applies to six

cases of septic arthritis of shoulder and elbow.

The haematogenous cases had an average period of hospitalization of one hundred and fifty-three days and wore plaster of Paris an average of sixteen weeks. It may be noted here that in the State Hospital it is not advisable to allow patients to leave supervision until entirely healed. In private practice patients could be discharged for long periods wearing plaster of Paris and returning for change of cast. This would greatly reduce the period of hospitalization.

Nine patients (over seven per cent) had pathological fractures, and four of them occurred while wearing plaster of Paris. This startling fact invites the question as to how many might have had pathological fractures if they had not worn plaster of Paris, and points to the need of adequate support to diseased bones as a means of preventing fractures.

There were five deaths among the one hundred and twenty-two patients with chronic osteomyelitis; one was operative; two were due to nephritis; and two were due to sepsis.

A study of the non-haematogenous cases showed that the period of hospitalization was longer than in the haematogenous cases —an average of one hundred and seventy-one days as against one hundred and fifty-three days; and that plaster of Paris was worn longer—an average of four and one-half months as against four months in the haematogenous cases.

Information as to the present condition of one hundred and four of the one hundred and sixty-two cases was obtained either by direct examination or by letter. Eighty-nine, or eighty-six per cent, of the one hundred and four cases healed and have remained so. Six drained intermittently but are now closed; four drain intermittently and at the present time. Five patients reported no benefit from treatment at all.

Ten patients, or nine per cent, have received treatment since discharge from the hospital; of these, six (five and one-half per-cent) have had operations. Thirty patients, or twenty-nine per cent, stated that they have deformities as a result of the disease. It will be recalled that sixty-four patients were admitted with deformities. Ninety-one, or eighty-seven per cent, of the one hundred and four are able to follow a useful occupation, an economic point of great importance. Ninety-six, or ninety-one per cent, regard their present condition as satisfactory, while ninety-nine (ninety-five per cent) expressed satisfaction with the treatment received.

SUMMARY

Acute osteomyelitis is a disease which menaces the life as well as the limb of the patient affected, and it should be considered an operative emergency. Joint involvement as a complication of osteomyelitis leaves the patient with disability even though his lesion may finally become quiescent.

This study has shown that satisfactory end results can be obtained in a large percentage of cases of osteomyelitis. Orr has supplied the method.

Relation of the Life Insurance Examiner to the Company, the Agent and the Applicant*

By CHARLES M. GLEASON, M. D.
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Life insurance has become the greatest single stabilizing factor in our business system in time of financial stress such as we have faced since 1929. Much as we decry the habit of borrowing from beneficiaries, the fact remains that about $3,000,000,000 are now in circulation from that source.

This first line of the country's economic defense becomes such by mobilizing the savings of 55,000,000 policy holders who represent over $100,000,000,000 of insurance. Legal reserve insurance companies invest about $50,000,000 each week. The general staff appointed by these companies says to their regiments of enlisted wealth, "Go and get seed to plant in the valleys and on the

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uplands and prairies; go and get machines to reap the crops and thresh the grain; go and get cattle to browse upon the grasslands; go and build barns and stables; go and help the farmer to cultivate the soil. Go and provide transportation of the people and their goods; help to spin the nation's web of steel. Go and put up dwellings where the people may live and rear their families in comfort and health. Go. Build factories. Light cities and give power to industry. Lay out and surface highways. Give the children schools. And wherever you go, enlist new recruits for this army of peaceful conquest."

There are few physicians who make no insurance examinations, and still fewer who carry no insurance, yet how few of us who secure the material for safe selection of risks regard our Insurance work as an art, not a trade; a calling and not a business? When we accept an appointment as examiner how many regard our contract with the company based on the motto, "You cannot serve two masters."

Dr. Olson of the Central Life says, "When difficulties and misunderstandings arise between the examiner and the Home Office it is almost invariably due to a lack of knowledge on the part of one, of the problems, aims, and needs of the other."

Would it not be well to have an occasional symposium by leading medical directors such as has been prepared by the Ramsey County Medical Society of Minnesota in the past, where a free discussion might iron out some of the troublesome issues? Recently the House of Delegates of the Colorado Medical Society resolved: "that the Committee on Public Policy of the Colorado State Medical Society counsel the members of the Society to cooperate to the fullest extent with life insurance companies and their representatives in the expeditious transaction of their business in all its phases."

Insurance companies pay us nearly $20,000,000 a year and are second only to the railroads as a source of revenue, yet our colleges nearly all ignore this work entirely and our medical societies seldom give it any recognition. To be sure an occasional resolution is passed telling the medical directors what they must do, and then we move on as before, neither party regarding the wishes of the other.

It is our duty to the applicant to arrange for a prompt, thorough, courteous examination, done with the same care that we give a patient, always remembering that he comes as a friend and will leave as such if we prove to be a counselor as well as an examiner. He should understand that a thorough examination is necessary to protect the policy holders, one of whom he hopes to become. A hearty congratulation on his investment often means much to the man who is not sold to the insurance idea. Examinations require courtesy, honesty, moral courage, efficiency, and tact, and nearly all applicants appreciate a thorough examination if made under favorable conditions. If we demand quiet for our patients, why should we accept a commission from an agent to go to a boiler shop office to examine an applicant? If examinations are to be made outside the office we have the right to expect satisfactory conditions as much as the obstetrician who is obliged to attend a case outside the hospital.

The applicant, consciously or otherwise, is prone to omit features in family or personal history which might determine the decision of the medical director. After he has been coached by an over-enthusiastic agent who has told him that the examination will take only about 10 minutes, he is often sure that we are too particular and we must sell the idea of good examinations. In any case he considers his acceptance as a clear bill of health and an error on our part may cause permanent damage.

It is never well to tell an applicant how we regard his risk. There are many factors that influence home office decisions and should one of these cause rejection or substandard rating, both the applicant and agent are displeased with the examiner. We see the applicant as an individual, the medical director sees him as a member of a group. Again, the examiner assumes unnecessary responsibility when he decides what may or may not be material to the case.

Most of our troubles with the agents are due to the fact that we never get together. In 30 years of examining for a score of companies, I have been in session with agents

but once and then only as a listener. We are as guilty as they. Did you ever hear of an insurance agent being invited to talk to a local medical society? We examiners should assume an attitude of fairness, courtesy, firmness, and tact, always seeking respect, not friendliness. Medical Director Grosvenor of the Travelers says, "Examiners and Agents succeed in their relations when they meet on the ground of gentleman to gentleman." Agents should feel that the examiners only report findings, the medical director makes the decision. The agent has the right to expect expedition, and will meet us halfway if we appreciate his position. He can not penalize the examiner for thorough work if the medical department insists that all rules be obeyed in choosing the doctor. When the agent may choose the physician a premium is placed on careless work. As one highly respected examiner has said, "Companies should see that agents live up to the rules. Stand by the physicians and they will stand by you. We subconsciously do better work for companies that adhere rigidly to rules laid down."

It is always more satisfactory when the examiner can make the appointments or at least confirm the ones made by the agent. Many prefer to come to the office though the agent does not think so. The agent is always suffering from Anxiety Neurosis and we must act accordingly, even though it may be necessary to see that the applicant is thoroughly "sold" if the agent has failed to complete his job. My observation is that the majority of the agents are fair and that the obliging examiner will receive his proportion of the business. The crux of this is the attitude of the home office. The agent needs the firm, guiding hand of the medical department.

OBLIGATIONS

The insurance examiner's obligation is primarily to the company, secondarily to the agent, the applicant, and himself but it is well to feel free to make suggestions to the medical directors. We have all been provoked by what seems to be unnecessary details in the blanks, especially where many questions could be put into one group. However, the men who have spent a lifetime in studying the needs of their department must know better than we what is needed. In many cases a question that seems irrelevant must be answered for legal reasons. In any event the umpire's decision is always right.

Extra fees should be allowed for extra visits and observations, especially since the examiner is the only man connected with life insurance who is paid the same as before. Examiners are not wise if they encourage medical societies to memorialize insurance companies by threatening resolutions when the medical directors know as well as other physicians that a large majority of the examiners will never refuse to answer reasonable questions asked by medical directors. Less correspondence pertaining to the examiner's work should go to the agent and more solely to the examiner, and an occasional letter containing some favorable criticism might do as much good as several of opposite import. Correspondence with the physician who is to furnish information regarding previous history of the applicant should be direct and not through the agent and a copy of such correspondence sent to the examiner might help in many cases.

Transmission of our report to the company should be direct, but conditions are not ideal. The examiner and the medical department can agree that we often obtain information that should not be filtered through a layman's hands, but expedition is important. Doctor Turner of Des Moines says, "In one series, 25% to 30% were returned for alterations or corrections, many for 10 or more omissions or mistakes." Then there are the delays that occur when examiners do not remit promptly. Any information that the agent should not see may be sent directly to the company even though the agent does handle the report. Accuracy and prompt transmission by the examiner would help the medical department to call for reports direct. The best cure for inaccuracy is to have the office secretary file copies of all medical reports.

Dr. William Bolt of the New York Life says, "We realize, of course, that where the examination is allowed to be seen by the agent that occasionally an agent will en-

deavor to influence an examiner to minimize his findings. Human nature being what it is, we can not entirely stop this. Theoretically it would be better for the examiner if we had all examinations forwarded direct to the Branch Office or to the Home Office. Practically it turns out that so many of our own profession hold up examinations and forget to post them for a day or two that the consequent delay damages business to such an extent that we cannot pursue this course. We do allow the privilege of forwarding any examinations direct to the Home Office or to the Branch Office if they care to do so. Or, on the other hand, they may hand the examination in the ordinary way to the agent and send us a confidential letter expressing any doubts that he may have about the risk. An examiner may obtain from the Branch Office confidential forms for this purpose if he so desires."

It is not wise for medical department officers to make examinations in the field except in conjunction with the local examiner. Dr. Sykes of Connecticut General Life says, "Nothing will upset the morale of a local examiner more than to have a home office representative make an examination in the field without consulting the examiner. We must demonstrate our confidence in him by deeds as well as words."

I believe that the majority of examiners are absolutely fair to the company. Many of us can remember when some companies would not permit any family physician to examine his patient for life insurance even though he were an appointed examiner. It seemed to Dr. Fisher of the Northwestern Mutual that this reasoning was wrong, so such examinations were encouraged. Dr. Fisher says, "A few years ago 38,550 such cases had been accumulated and the mortality of the class was 12 points better than the general average mortality of the company for the same period. This certainly speaks well for the integrity of the man whose duty lies in one direction and his sympathy in another."

THE EXAMINATION

The examination requires skill and training. It is full of pitfalls for the beginner and the unwary. What we need is not more refined methods of diagnosis but more application of the means in general use. Director J. Allen Patton of the Prudential says, "Inspection or observation is one of the most essential features in the training of both clinician and insurance examiner, and the best results are obtained by those who have best developed this faculty." No one can state the relative importance of history and physical examination. Richard Cabot says; "If I had to choose between them I would rather have the history." Wenstrand says, "First, last and always it is the examiner's duty to report the facts as he finds them both as to history and physical condition. To do this, he should approach a life insurance examination as he does the examination of a patient who seeks a diagnosis and advice. There really is no difference between the two except that a life insurance medical examination blank contains specific questions which assist the doctor in eliciting the history and in recording the physical findings. Again let it be said that facts are essential, for then and only then is the home office selector able to evaluate the risk." When an examiner reports a considerable series of applicants with identical blood pressure, and urine records all between 1018 and 1022, what is the inference? Dr. Herbert Old of the Providence Mutual has said, "No question blank is sufficient in the hands of a careless, mechanical or dishonest examiner."

It is the opinion of the medical director of the Travelers that, "Medical examiners are the keystone of the arch in the selection by life insurance companies. Selection by the medical examiner in making accurate physical examinations, solicitation of accurate personal and family histories and the expression of opinion as to viability of the risk, as a whole operate always to the success of a company provided the examiner is competent and conscientious. I am sure no larger proportion of any group of men is so constituted than is the case in a group of physicians acting as examiners for well operated life insurance companies."

And what may we profit from our insurance work? In the first place collections are

100%. It allows ethical broadening of professional acquaintance and professional contact with impaired and unimpaired risks. It stimulates accurate history writing and study of physical findings which used to be considered important before we acquired the habit of referring so much to the laboratory technician. It identifies us with health conservation. It increases knowledge of prognosis by contact with vital statistics of insurance companies. It is educational in that it furnishes opportunity to see variations within normal range and to study well people.

THE JOURNAL CLINIC

Tularemia; Report of Case From Bite of a Cat

By C. J. SMILES, M. D.
Ashland

Because I know of no case of tularemia that has followed the bite of a domestic cat, the following case is placed on record.

On July 10th, 1931, a nine year old boy, D. J., was brought to me because of a high fever for the past four days and a lump under his right arm which had appeared two days previously. The parents had visited a well informed doctor when the fever began, but made no mention of any injury. The doctor found the boy very ill with a temperature of 105 and a pulse of 160. He was vomiting and his neck was slightly rigid. A tentative diagnosis of meningitis was suggested but no spinal puncture was made. The general condition remained the same but the glands in the epitrochlear, axillary and supra-clavicular regions enlarged so that when he came to our office he had a well developed adenitis. The mother then for the first time told of the boy having been severely bitten on the right index finger on July 3rd, while fondling a two months' old kitten that was obviously ill. The wound had been surgically cleansed, painted with mercurochrome and forgotten until this history was obtained. The cat died two days later and was buried in the garden.

Upon examination the boy was thin, anxious, and obviously ill, with a temperature of 103.4, pulse 96. On the proximal phalanx of the right index finger were several small puncture wounds made by the teeth of the cat. The openings were infected, the finger swollen and each tooth mark had hard margins with an ulcerated center and was secreting thin gray pus. There was no lymphangitis to be seen but there was a large soft glandular swelling just above the middle of the clavicle. The boy carried himself stiffly and it was with difficulty that he could be induced to move his arm or head.

He was sent to the hospital for the necessary laboratory work:

Urine showed only a trace of albumen and a few white blood cells.

Blood count: R. B. C., 3,650,000; Hb, 70%; W. B. C., 16,800.

Blood test showed positive agglutination for B. tularense. The blood culture was negative.

Temperature of septic type, range was 99.4 to 103.4 degrees.

A temporary program of hot dressings to the wound was started. Iodide of lime internally was given to tolerance.

On July 15th, an incision into the axillary nodes revealed much necrotic material but no frank pus. As much lymphoid material as possible was removed and the cavity packed with gauze. The epitrochlear and supra-clavicular nodes were not disturbed. The histologic report was:

A number of irregular pieces of tissue firm and white, homogeneous on section.

Microscopic: Lymphoid tissue with large diffuse areas of degeneration.

Diagnosis: Hypertrophy and degeneration of lymphoid tissue.

Convalescence began almost at once. The appetite returned and weight increase began. A slight temperature in the afternoon

of 99.7 to 100.2 degrees remained to September 21st, at which time it fell to *99*. The remains of the adenitis still show as small fibrous nodules but the boy is symptomatically well. On August 7th, a one-third erythema unfiltered dose of x-ray was given over the involved nodules. We thought the nodules were hastened in resolution by this procedure.

The body of the cat was too decomposed when a diagnosis had been made to be examined. The source of the disease in this young animal may have been from a bite of a wood tick in which this country abounds, or from the ingestion of portions of a tick-infested rabbit or ruffed grouse. Wisconsin rabbits and ruffed grouse were almost exterminated by a disease three years ago and many of the animals and birds observed to be ill had wood ticks in great numbers attached to them, and some rabbits had the typical liver of tularemia. This disease had been found in the domestic rabbit a short time ago and now is found to be transmitted by a cat bite. The significance of this in relation to domestic stock, fur farming, etc., is evident.

University Announces Course in Urology for General Practitioners

Under the direction of the Department of Urology of the University of Wisconsin a series of one-day clinics for practitioners will be given during the winter months. The dates of these clinics are January 5, February 2, March 1 and April 5.

The morning programs will include dry and operative clinics, case reports, demonstrations of methods and procedures useful in practice, demonstrations of technique of trans-sacral, spinal and other forms of local anesthesia, and discussions of the pathology of the various genito-urinary diseases. These programs will be presented by Dr. I. R. Sisk and associates of the Department of Urology, Dr. Ralph M. Waters and associates of the Department of Anesthesia, and Dr. William Stovall and associates from the Department of Pathology.

The afternoons will be devoted to lectures bearing on the practice of Urology. These will be given by members of the faculty of the Medical School. Some of the subjects which will be discussed are: "The Preoperative and Postoperative Management of Diabetes" by Dr. Elmer L. Sevringhaus, Associate Professor of Medicine; "Heart Disease as it Relates to Surgery" by Dr. Robert Van Valzah, Professor of Clinical Medicine; "Urinary Secretion" by Dr. Walter Meek, Professor of Physiology; "Routine Urinalysis as Applied to Clinical Diagnosis" by Dr. William Stovall, Director, State Laboratory of Hygiene; "Kidney Function Tests in Office Practice" by Dr. Elmer L. Sevringhaus, Associate Professor of Medicine; "Surgical Anatomy of the External Genitals and Perineum" by Dr. J. B. Wear, Assistant Professor of Urology; "Obstetrical and Gynecological Problems Relating to Urology" by Dr. John W. Harris, Professor of Obstetrics and Gynecology.

This course is given to increase the general practitioner's knowledge in the field of Urology, Pathology and Anesthesia. While it may be of interest to men who specialize in Urology, it is especially planned for the general practitioner. Men attending these conferences are requested to register before January 1, either with Mr. George Crownhart, Secretary of the State Medical Society, or Dr. I. R. Sisk. There will be no fee charged for this course. A detailed program will be mailed every person who signifies his interest by registering one week previous to the meeting.

NOTICE OF AMENDMENT

Pursuant to Article XIII of the Constitution, the Secretary reports that the following amendment to the Constitution, proposed by Dr. Spencer D. Beebe of Sparta, will receive action at the 1932 meeting of the House of Delegates.

Amend Article V "House of Delegates" to read:

"ARTICLE V

"House of Delegates

"The House of Delegates shall be the legislative body of the Society and shall consist of delegates elected by the component county societies. The officers of the Society enumerated in Section I of Article IX of this constitution, and past presidents of the Society, shall be ex-officio members of the House but without right to vote."

THE WISCONSIN MEDICAL JOURNAL

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OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

EDITORIALS

PERIODIC HEALTH EXAMINATIONS

THE Milwaukee County Medical Society recently devoted an evening to the question of periodic health examinations. The introduction of a new examination form and its demonstration aroused considerable discussion which indicated the interest of the profession of this question. Agitation for a periodic health examination, both among the medical profession and the laity, has increased astonishingly during the past decade. That the solution of this problem will not be a simple one is borne out by the fact that thus far no concerted program has been evolved. The value of the periodic health examination is beyond question and its promotion is a worthy project for the consideration of medical societies.

Two questions come to mind which will strongly effect the satisfactory solution of this problem. All too frequently people become interested in a periodic health examination at a time when preventive measures are already past consideration. If the full value of the periodic health examination is to be realized it should be started early enough in life so that the inherent tendencies of the individual can be properly evaluated and corrective advice given when it will do some good. Ideally this would mean that periodic health examinations should be started at birth and continued until the death of the individual. At least, successful health guidance should start in childhood and should be as much a part of the child's training as any other phase of his educational development. The responsibility for development of such interest lies heavily upon those closely associated with children. If the child is trained to have these periodic examinations, he is very likely to continue this when he reaches an age of responsibility, and with this background the peculiarities of an individual and the earliest signs of abnormality can be more satisfactorily evaluated.

The second phase of this problem, which seems of fundamental importance, has to deal with the accumulation of data in these supposedly normal individuals. If satisfactory standards for comparison with the normal are to be evolved, they should come from mass statistics derived from these innumerable health examinations. Herein lies an opportunity for the individual practitioner to contribute information of fundamental value, and it places a responsibility upon the medical profession to evolve some means of accumulating, classifying and correlating this material.

In conclusion, the successful culmination of a program for periodic health examinations will of necessity be slow because it will be primarily an educational process. Efforts to stimulate such a program by compulsion, creation of fear in the minds of the laity or by furnishing such service to the economic disadvantage of the medical profession, will

We Wish You A Happy Holiday Season

be shortsighted and will delay, if they do not actually destroy, the full realization of its possibilities. J. H.

MEANS TO AN END

WHO of us not a better clinician because of knowing how to use a modern stethoscope and sphygmomanometer? These two instruments among many have led to a much more thorough and careful investigation of cardio-vascular diseases than would have been possible otherwise; and we, by the means of this accumulated and organized knowledge, now can recognize easily the particular type of condition our patient has because we follow through a study of the patient in which the blood pressure and the heart sounds occupy positions similar to guide posts on a highway. They are not the road or the country, but the markers. All instruments of precision are that and *nothing more.* He who travels the highway and sees naught but the guide posts is perfunctory and superficial. It is only when the guide posts are used as such to keep us on the highway that they really serve. The destination is death or recovery; the guide posts lead to both. Whether our patient arrives at one or the other often depends on what we have observed along the way *in addition to* the markers.

All instruments and laboratory procedures have been developed as means of accumulating data and amassing knowledge, which when organized and digested widens and improves our clinical experience and sharpens and matures our clinical judgment. Information so gathered does not and cannot ever replace careful clinical study. It guides our judgment but should rarely determine it.

The list of diagnostic tests is ever increasing. But it is a very dangerous dependence when we become slaves to laboratory technique and expect a test tube, or a microscopic slide, or a roentgenogram, or a pyelogram, or a cholecystogram to be the pathognomonic sign which points to the diagnosis and proper treatment and which encourages us to become lazy and narrow in our own thinking.

In very many instances all that our precise methods do is to increase the difficulty of our judgments. We cannot conclude that a nonfunctioning gall bladder is the cause of symptoms and requires surgery merely because of a Graham test. Many patients lose their gall bladders and keep their symptoms because of such loose thinking and too close dependence on a single laboratory procedure.

The highway of medical practice requires an ever widening sense of values and closer application of all our senses to the problems in hand. It is not a question of blindly following guide post, but of avoiding accidents, watching the highway and cross roads, and knowing the country, mapping the terrain. The guide posts are invaluable when right, but are sometimes wrong.

Let us give every patient careful clinical study and use the instrument of precision as a means to an end, not as the end itself. Used as an end it becomes the tail wagging the dog. H. P. G.

THE PATHOGENESIS OF MALIGNANT NEPHROSCLEROSIS

THE pathological changes in the kidneys which result from continued hypertension are most important, for it is upon the integrity of these organs that life, barring vascular accidents, depends. All physicians of any number of years' experience have seen cases of hypertension of extreme grade lasting over a long period of years, so that the hypertension in itself may not be and often is not a serious handicap to an individual.

In spite of the enormous amount of work which has been directed toward the solution of the etiology of hypertension, the cause or

causes have never been definitely found. At present the general belief is that some psychic effect, circulating poison or endocrine imbalance causes widespread vasoconstriction and this eventually leads to pathological changes in the arterioles of the organs. Of all the organs the kidneys are by far the most important. It will be recalled that Volhard maintains that ischemia, the result of contraction of the pre-glomerular afferent arterioles, is the chief cause of the slowing down of the kidneys as well as the cause of the necrobiosis seen in the arteriolar walls. It is to be recalled that the process of nephrosclerosis is always patchy. Even in the most severely damaged kidneys many glomeruli are intact. The Volhard idea has never been universally accepted as there were many factors which were not thoroughly explained by this hypothesis.

The pathogenesis of nephrosclerosis has been a subject in which much polemic has been bandied back and forth. Likewise much good ink and paper have been used up in the discussion of the relationship of benign to malignant hypertension. Some considered the latter to be just a further extension of the former, others believed that infection was added to the former in order to produce the latter.

Schapiro* has recently restudied the subject using an India-ink injection of the kidney shortly after removal at autopsy. He studied such injected kidneys both in selected sections and in serial sections. He reminds us of the gross pathological and of the microscopic pictures seen by the usual methods. He calls attention to the fact that the ordinary fixed and stained microscopic sections give no idea of the arterioles and capillaries while blood was coursing through them. He finds that there is ischemia but that the ischemia is not a lack of blood, on the contrary it is too much blood collected in dilated capillary loops which have no circulation. He calls the condition hyperemia with retardation. It is impossible to give in a brief space even an abstract of his discussion. The essential features of the pathogenesis are as follows:

During life the nephrosclerotic kidney is markedly hyperemic, not anemic. The arterioles have a double nerve supply, constriction and dilatation. A moderate stimulus produces moderate contraction, a strong stimulus produces marked contraction, excessive stimulus produces a loss of constrictor tonus, with paralysis. Dilator tonus is less sensitive and is retained after constrictor tonus is lost. Excessive stimuli result in dilatation, not contraction. "The arterial tree reacts segmentally. Its peripheral portions are progressively more sensitive than the proximal portions. A stimulus that is sufficiently strong to cause marked contraction of a larger artery constitutes an excessive stimulus for the capillaries and arterioles and results in their dilatation."

The flow through the affected glomeruli served by the narrowed afferent arterioles is much retarded. Dilatation of capillaries especially near the hilus of the glomerulus results and nutrition is affected. As the process advances, too much nutriment from blood stasis brings about tissue proliferation with finally anemic necrosis of the arteriolar wall and then polymorphonuclear infiltration, giving an appearance of acute inflammation. When enough of the glomeruli are the subject of this hyperemia with retardation of flow and enough of the afferent arterioles are affected by the necrobiosis, the kidneys suddenly cease functioning and uremia sets in. "There is no fundamental difference in the pathogenesis of benign and malignant nephrosclerosis, whatever their respective etiologies may be. Both depend, however, not on glomerular ischemia or on arteriolar occlusion, but on a hyperemia associated with a retardation of flow . . . Moderate retardation leads slowly to the organic changes of benign nephrosclerosis. Severe retardation rapidly induces the pathologic changes of malignant nephrosclerosis and terminates in uremia."

The author's careful work with his convincing illustrations is an important contribution to this much discussed subject. It reconciles the several hypotheses which have been advanced to explain the disease. By the use of an experimental method he has furthered our knowledge of one of the most baffling of modern diseases. L. M. W.

* Arch. Int. Med., 48:199–234, 1931 (Aug.)

THE PRESIDENT'S PAGE

THE ORTHOPEDIC HOSPITAL

ON NOVEMBER 8th there was dedicated and officially opened to the public the new Orthopedic Hospital at the University of Wisconsin. As physicians, we are always interested in the opening of any institution in which the public shall have available better facilities and means for accurate diagnosis and treatment of illness. Hospitals are the workshop of the profession and enable it to render better service.

We congratulate the Wisconsin Association for the Disabled and especially its executive secretary, whose activities have reached their fruition in this institution. Lay organizations of this character have a very definite place in our social life in making manifest to the social body the needs of the citizens. They conduct an educational campaign which, because of public reaction, the physician is unable to pursue. Such a program on the part of the organized units of medicine would arouse in the lay mind the thought of professional self-interest.

The institution is a comparatively modern agency. It is only because of the rapid strides that curative surgery, physiotherapy, and medical science generally have made, that we shall be able to rehabilitate and to return to useful lives the hundreds of victims of disease and accident who shall be treated there, and who until recently would have been forced to go through life maimed, crippled, and dependent. As a profession we are proud of our history of thousands of years of service that has resulted in restitution to health and in extension of life to millions of people. We recognize that curative practice and curative institutions must be provided so long as preventive medicine is not universally employed or available, and until our knowledge of disease is further extended in some fields. We regret that because of ignorance or economic strain all the people do not or can not avail themselves at all times of such preventive measures as are known to the profession.

In the medical as in the economic and educational fields, the great problem today is distribution of service. The span of life can be increased by several years, much invalidity prevented, morbidity reduced and economic productivity of labor maintained if the knowledge which the profession possesses and which is available to the public were employed and always within the reach of those in need of it. We are looking forward to the day which shall see the need of institutions of this character materially reduced; when the medical profession shall fulfill its full obligation and function so as to make available to all the people all that is best in medical service at a fee within the ability of the recipient to pay. Probably the profession can only point the way. The public must realize the need and provide the means.

The institution will serve another than a curative and rehabilitating function in that it will be used as a teaching hospital in which novitiates in medicine will receive such training as shall enable them to make earlier diagnosis, institute earlier and more effective treatment and thus reduce the incidence of chronic and disabling diseases.

The public must be reminded that it is prevention which the profession desires and labors to provide. This will best be secured through those who are in the front rank in the battle for health—the general practitioners. As we promote local facilities that make possible more immediate and accurate diagnosis and treatment, as we better train our students and better insure their interests and abilities and as we devise means that shall make it possible to have a physician readily available to every person in our commonwealth at all times, then and only then, shall we accomplish our end in preventive medicine.

The institution then holds possibilities for great benefit to the people of our State. By cooperation between the institution, lay organization and the medical profession, it should be a means of advancing medical knowledge and treatment in our communities, should demonstrate to the public the need of early adequate medical care, impress on the minds of all the need of preventive medicine, and through the relief it will bring to those suffering from disabilities, it will bring happiness and joy to hundreds of households and to thousands of individuals. Such a program has the full sympathy and will have the hearty cooperation of the medical profession of the State.

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REGINALD JACKSON, Madison, Pres.-Elect
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Brown-Kewaunee	A. J. McCarey, Green Bay	E. S. Knox, Green Bay.
Calumet	A. C. Engel, New Holstein	A. F. Slaney, Hilbert.
Chippewa	F. T. McHugh, Chippewa Falls	J. A. Kelly, Chippewa Falls.
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Columbia	A. J. Batty, Portage	H. E. Gillette, Pardeeville.
Crawford	A. E. Dillman, Steuben	C. A. Armstrong, Prairie du Chien.
Dane	F. F. Bowman, Madison	L. V. Littig, Madison.
Dodge	E. P. Webb, Beaver Dam	A. W. Hammond, Beaver Dam.
Door	John Hirschboeck, Forestville	
Douglas	J. W. McGill, Superior	C. H. Christiansen, Superior.
Eau Claire and Associated Counties	E. E. Tupper, Eau Claire	P. G. Spelbring, Eau Claire.
Fond du Lac	J. C. Yockey, Fond du Lac	H. R. Sharpe, Fond du Lac.
Grant	E. A. A. Dunn, Platteville	M. B. Glasier, Bloomington.
Green	W. B. Gnagi, Sr., Monroe	J. F. Mauermann, Monroe.
Green Lake-Waushara-Adams	J. M. Johnson, Ripon	A. J. Wiesender, Berlin.
Iowa	T. A. Hagerup, Dodgeville	H. M. Walker, Dodgeville.
Jefferson	Will Young, Ft. Atkinson	M. G. Peterson, Lake Mills.
Juneau	C. A. Vogel, Elroy	A. T. Gregory, Mauston.
Kenosha	W. H. Bennett, Kenosha	W. H. Lipman, Kenosha.
La Crosse	W. J. Jones, La Crosse	R. L. Eagan, La Crosse.
Lafayette	R. B. Quinn, Darlington	W. B. Williams, Argyle.
Langlade	E. J. Donohue, Antigo	J. C. Wright, Antigo.
Lincoln	F. L. Kelley, Merrill	W. H. Bayer, Merrill.
Manitowoc	W. G. Kemper, Manitowoc	C. H. Barnstein, Newton.
Marathon	Joseph F. Smith, Wausau	Verne E. Eastman, Wausau.
Marinette-Florence	T. J. Redelings, Marinette	C. H. Boren, Marinette.
Milwaukee	E. L. Tharinger, Milwaukee	Theo. Wiprud, Ex. Sec'y, Milw.
Monroe	A. E. Winter, Tomah	H. H. Williams, Sparta.
Oconto	R. J. Goggins, Oconto Falls	G. W. Krahn, Oconto Falls.
Oneida-Forest-Vilas	C. D. Packard, Rhinelander	I. E. Schiek, Rhinelander.
Outagamie	J. L. Benton, Appleton	R. V. Landis, Appleton.
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Polk	L. O. Simenstad, Osceola	Geo. B. Larson, Frederic
Portage	F. A. Marrs, Stevens Point	H. P. Benn, Stevens Point.
Price-Taylor	F. W. Mitchell, Medford	G. E. MacKinnon, Prentice.
Racine	J. F. Bennett, Burlington	Susan Jones, Racine.
Richland	Bertha Reynolds, Lone Rock	G. Benson, Richland Center.
Rock	H. E. Burger, Beloit	E. C. Hartman, Janesville.
Sauk	Roger Cahoon, Baraboo	A. C. Edwards, Baraboo.
Shawano	C. E. Stubenvoll, Shawano	L. W. Peterson, Shawano.
Sheboygan	John Hansen, Glenbeulah	A. C. Radloff, Plymouth.
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SOCIETY PROCEEDINGS

ASHLAND-BAYFIELD-IRON

The October meeting of the Ashland-Bayfield, Iron County Medical Society was held Wednesday evening, October 28th, at the Knight Hotel, Ashland. The following officers were elected for the coming year, 1932.

President, Dr. John Dodd, Jr., Ashland.

Vice President, Dr. John K. Schumate, Bayfield.

Sec. and Treas., Dr. J. W. Prentice, Ashland.

Censor for three years, Dr. W. J. Tucker, Ashland.

We had as our speaker, Dr. M. G. Peterman of Milwaukee through the courtesy of Marquette University.

Dr. Peterman's paper on "The Kidney Diseases of Childhood" was most admirably presented in that it was sufficiently comprehensive and yet clear, concise and practical from the standpoint of the general practitioner. J. W. P.

BROWN-KEWAUNEE

The monthly meeting of the Brown-Kewaunee County Medical Society was held at the Hotel Beaumont, Oct. 29th. Dr. Samuel Haines of Rochester, Minn., held a goiter clinic at 5:30 P. M. Several interesting cases of exophthalmic goitre were shown. The cases were brought in by the doctors of the society. After the clinic, dinner was served to about 40 doctors from Green Bay and the surrounding cities.

Immediately following dinner Dr. Haines gave a talk on the "Diagnosis and Differential Diagnosis of Goitre". The subject was very well handled and the physicians present were very well pleased with the talk.

At the business meeting following the scientific part of the program, the following business was transacted. A card was read which was received from Dr. and Mrs. T. J. Oliver expressing their appreciation for the part the society took during the recent loss of Mrs. Oliver's father, Dr. Brett.

The following doctors were admitted to the society as new members: Dr. Alvin J. Dupont, Pulaski; Dr. E. W. Exley, Green Bay, and Dr. Karl Icks, Green Bay.

There being no further business the meeting was adjourned. E. S. K.

CRAWFORD

The annual meeting of the Crawford County Medical Society was held on October 29th. Following a dinner at Kaber's Restaurant, Prairie du Chien, the meeting was adjourned to the Court House.

Dr. A. W. Bryan of Madison was the guest speaker, and Dr. F. J. Antoine, mayor of Prairie du Chien gave the address of welcome in his usual happy manner.

The members were very happy to have their President, Dr. A. J. McDowell of Soldiers Grove, present and to know that he is regaining his health.

Officers elected for 1932 are: President, Dr. A. E. Dillman, Steuben; Vice-President, Dr. W. T. Pinkerton; Secretary and Delegate, Dr. C. A. Armstrong; Alternate, Dr. J. J. Kane,—all of Prairie du Chien. C. A. A.

DOUGLAS

Members of the Douglas County Medical Society held a dinner meeting on Wednesday, October 28th, at the Androy Hotel, Superior, at six-thirty.

Dr. James C. Sargent, clinical professor of urology, Marquette University Medical School, spoke on "Intravenous Urography and Floating Kidney," and Dr. M. G. Peterman, professor of pediatrics, also of Marquette, discussed "Problems of Pediatrics."

FOND DU LAC

The annual meeting of the Fond du Lac County Medical Society was held at Hotel Retlaw on November 11th, at which the following officers were elected: President, Dr. J. C. Yockey; Vice-President, Dr. D. V. Meiklejohn; Secretary-Treasurer, Dr. H. R. Sharpe, re-elected; Censor, Dr. D. J. Twohig, re-elected,—all of Fond du Lac. H. R. S.

GREEN

The annual fall banquet and meeting of the Green County Medical Society was held in the Ludlow Hotel, Monroe, November 10th.

Speakers at the gathering included Dr. Erwin P. Schmidt, professor of surgery; Dr. Ira R. Sisk, professor of urology, and Dr. John W. Harris, professor of obstetrics and gynecology,—all of the University of Wisconsin Medical School.

Approximately thirty physicians attended the meeting.

GREEN LAKE-WAUSHARA-ADAMS

Members of the Green Lake-Waushara-Adams County Medical Society and their wives held a meeting at Princeton on October 29th. Following a duck dinner at the American House at seven o'clock they were entertained at the home of Dr. and Mrs. G. G. Mueller of Princeton and after a short business meeting, bridge was played the remainder of the evening. Prizes were won by Dr. B. E. Scott of Berlin and Mrs. C. U. Senn of Ripon.

MARINETTE-FLORENCE

The following officers were elected at the annual meeting of the Marinette-Florence County Medical Society held recently: President, Dr. T. J. Rede-

lings; Vice-President, Dr. H. F. Schroeder; Secretary, Dr. C. H. Boren; Censors, Drs. M. D. Bird, J. W. Boren, J. V. May; Delegate, Dr. G. R. Duer; Alternate, Dr. J. V. May; Committee to cooperate with the local health department, Drs. T. J. Redelings, G. R. Duer, H. F. Schroeder, C. H. Boren; Program committee, Drs. A. T. Nadeau, G. R. Duer, M. D. Bird.

Dr. A. T. Nadeau spoke in appreciation of the many years of faithful service rendered by the retiring Secretary, Dr. M. D. Bird and presented a desk fountain pen set to Dr. Bird as a gift from the society.

Members of the Society attended the funeral of Dr. David R. Landsborough of Daggett, Michigan, who died on October 28th at the age of sixty. Even though he lived in Michigan, Dr. Landsborough always attended the meeting of the Marinette–Florence County Medical Society.

Active pall bearers were Dr. T. J. Redelings and Dr. M. D. Bird, of Marinette. Dr. W. S. Jones and Dr. S. C. Mason of Menominee, Mich., Dr. Edward Sawbridge, Stephenson, Mich., and Dr. A. R. Peterson of Daggett, Michigan.

A motion was passed expressing the sympathy of the society members to the members of the family of Dr. D. R. Landsborough.

Dr. Ralph Carter of Green Bay, Wisconsin, presented a paper with movie film illustration on "The Modern Care and Treatment of Fractures of the Femur." C. H. B.

MILWAUKEE COUNTY

At the monthly meeting of The Medical Society of Milwuakee County, held in the Red Room of the Hotel Pfister on November 13th, the following scientific program was presented:

"Mediastinal and Pulmonary Tumors," Dr. Chas. Spencer Williamson, professor of medicine, University of Illinois College of Medicine.

"Indications for and Results of Phrenic Nerve Block," Dr. Forrester Raine, Milwaukee.

By a unanimous vote the Society adopted a resolution, presented by Dr. L. M. Warfield, calling upon the city council to continue the appropriation providing for emergency service at the Johnston Emergency Hospital whereby four part-time physicians are employed. This resolution is similar to one recently forwarded to the board of estimates of the common council by the board of directors of this Society.

Following the scientific meeting there was a social hour. There were 250 members present.

POLK

The Polk County Medical Society held its regular monthly meeting at the home of Dr. Geo. B. Noyes, Centuria, on October 15.

Judge Carl M. Lynn gave an interesting discussion of the revised poor relief laws of Wisconsin, as they affected the physicians of Polk County. A mutual understanding of our respective positions resulted from the round table discussion following Judge Lynn's paper.

The following officers were elected for the ensuing year: Dr. L. O. Simenstad, President; Dr. Geo. B. Noyes, Vice President; Mr. Geo. B. Larson, Secretary; Dr. R. G. Arveson, Delegate, and Dr. J. D. Nicholson, alternate.

The possibility of the Polk County Medical Society sponsoring a Child Health Center Clinic was brought before the Society. The subject was referred for investigation.

Dr. R. G. Arveson, delegate, gave a report of the proceedings of the House of Delegates.

At the close of the meeting the Society was presented with a cake bearing one candle, signifying the first anniversary of the Society. G. L.

ROCK

Dr. Max Cutler, Chicago, and Dr. John L. Yates, Milwaukee, were speakers at the monthly meeting of the Rock County Medical Society held at the Myers Hotel, Janesville, on October 20th. Dr. Cutler spoke on "Indication for the Use of the Radium Knife" and Dr. Yates discussed "Diagnosis of Tumors of the Breast." A dinner preceded the program.

TREMPEALEAU–JACKSON–BUFFALO

At a meeting of the Trempealeau–Jackson–Buffalo County Medical Society on October 8th, Dr. I. H. Lavine of Melrose was elected to membership in the Society.

MILWAUKEE ACADEMY OF MEDICINE

Members of the Milwaukee Academy of Medicine met on Tuesday, November 10th, at eight o'clock.

Dr. Norbert Enzer, Milwaukee, gave a presentation of pathological specimens, and Dr. Albert E. Russell, past assistant surgeon, U. S. Public Health Service, spoke on "Dust as an Etiological Factor in Pulmonary Disease."

The following memorial note was accepted by the Academy at this meeting on the death of Dr. Henry V. Ogden:

"Your committee deems it an honor to be entrusted with the duty of preparing a suitable Memorial Note on the death of Henry Vining Ogden.

"One of the Founders and a President of the Milwaukee Medical Society, later the Milwaukee Academy of Medicine, Dr. Ogden has been one of the most valued and active members of the Society for forty-five years. During all this period, he has stood true to the interest of this organization and true to the ideals of medicine. His altruistic interest had also its practical side as evidenced by his activity in the promotion of medical education as expressed by his success as chairman of the committee on the endowment fund of the Medical

Department of Marquette University, the establishment and conduct of Columbia Hospital and his long and valued service to the Milwaukee Hospital and to the Milwaukee Children's Hospital. He belonged to an era in medicine which, in this strenuous commercial age, seems at times to be disappearing in the mists of the past, when only here and there shines the light of the scholar, the kindly physician, the gentleman, the scientist who maintains through life steadfast devotion to scientific medicine unaffected by the modern spirit of commercialism.

"Such men as these are all too rare in the medical profession. They often live their noble lives without apparent obvious reward except that of duty well performed and the appreciation of those who know them. 'When the ear heard him, then it blessed him; when the eye saw him, it gave witness of him; he delivered the poor that cried, the fatherless, and him that had none to help him. Kindness, meekness and comfort were on his tongue. If there was any virtue, and if there was any praise, he thought of those things. His body is buried in peace but his name liveth.' Such a man was Henry Vining Ogden.

"In his death, the Academy of Medicine, the Community and his family have sustained an irreparable loss. To the generation of physicians who knew him in the early maturity of his professional life—and who were the beneficiaries of his friendship, counsel and inspiration—his rare spirit will continue to live on. Grateful for the example and beneficence of his life and expressing the hope that of such men it may still be said, 'Truly their works do follow them' the Academy of Medicine stands in respectful salute at the passing of our beloved friend and colleague."

Respectfully submitted,

Gilbert E. Seaman,
Hoyt E. Dearholt,
Otto H. Foerster.

MILWAUKEE HOSPITAL INTERNS' ASSOCIATION

A very successful meeting of the Milwaukee Hospital Interns' Association was held at the home of Dr. Edward Jackson on November 17th. Dr. Francis D. Murphy was the speaker of the evening and he presented a most interesting discussion on the subject of "Nephritis." There were thirty members present.

Following the scientific discussion all present were guests of Dr. Jackson at a buffet supper.

The next meeting of this Association will be held on December 16th at the Milwaukee Hospital. This will be a dinner meeting.

MILWAUKEE OTO-OPHTHALMIC

The November meeting of the Milwaukee Oto-Ophthalmic Society was held at the Wisconsin Club on Tuesday, November 17th, with a dinner served at six-thirty o'clock.

Dr. Joseph Beck of Chicago was the guest speaker of the meeting, who spoke on "Malignancies about the Nose and Throat and How Affected by Irradiation." Dr. Beck also discussed the effect of radical laryngeal operations on the voice.

MILWAUKEE PEDIATRIC

The Milwaukee Pediatric Society held the last meeting of the year at the Children's Hospital on the evening of December 9th. At this time officers were elected for 1932, and the following program was presented:

"True Cerebral Hemorrhage of the Newborn," Dr. Abraham Levinson, Chicago.

"Indications for Collapse Therapy in Children," Dr. Karl E. Kassowitz, Milwaukee.

MILWAUKEE ROENTGEN RAY

A meeting of the Milwaukee Roentgen Ray Society was held Friday, November 20th, at the Wisconsin Club with dinner at 6:45 followed by a scientific program at 8:15. There were 33 members and guests present at the dinner, the guest of honor being Dr. H. K. Pancoast, professor of roentgenology at the University of Pennsylvania. The speaker's subject was "Pneumoconiosis". After a most thorough and interesting presentation of the subject by Dr. Pancoast, the paper was discussed by Drs. Warfield, Gray, Tharinger, Enzer, Lotz, and Smith. In addition to the medical men present, there were about 15 or 20 additional people present during Dr. Pancoast's presentation, these being chiefly industrialists interested in the subject of pneumoconiosis from the standpoint of workmen's compensation. J. E. H.

FIRST DISTRICT

The annual meeting of the First Councilor District of the State Medical Society of Wisconsin was held on November 18th at three P. M., at Municipal Hospital, Waukesha. Members from Dodge, Jefferson and Waukesha counties attended.

The program opened with a business meeting and an address by Dr. Arthur W. Rogers, Oconomowoc, Chairman of the Council of the State Society. Following this Dr. A. W. Bryan, Madison, read a paper on "Heart Disease: Certain Phases of Its Management", and Dr. M. G. Peterman, director of Milwaukee Children's Hospital, talked on "Convulsions."

Dinner was served to the members at six o'clock at the Hospital. An address by Dr. Carl W. Eberbach, Milwaukee, on "The Goiter Problem in the Great Lakes Region" completed the program.

WISCONSIN ANTI-TUBERCULOSIS ASSOCIATION

The annual meeting of the Wisconsin Anti-Tuberculosis Association was held on November 2nd and 3rd at the Health Service Building, Milwaukee. Dr. R. D. Thompson, superintendent of Wisconsin State

Sanatorium, was chairman of the medical section. Speakers and their subjects on this part of the program were the following:

"A Changing Viewpoint in the Treatment of Tuberculosis", Dr. William S. Middleton, Associate Professor of Medicine, University of Wisconsin.

Discussion—"Contributing Factors"

"Scientific Research", Dr. L. L. Allen, Muirdale Sanatorium, Wauwatosa.

"Laboratory Aids", Dr. Florence E. MacInnis, Medical Department, W. A. T. A.

"Chest Surgery", Dr. W. C. Reineking, Superintendent, Lake View Sanatorium, Madison.

"The Newer Facts on the Childhood Type of Tuberculosis", Dr. J. A. Myers, Professor of Medicine University of Minnesota.

Discussion

"Factors in Diagnosis", Dr. R. C. Meyer, Rocky Knoll Sanatorium, Plymouth.

"Treatment", Dr. K. E. Kassowitz, Muirdale Sanatorium, Wauwatosa.

"Where Shall Tuberculous Children Be Treated?", Dr. Oscar Lotz, Medical Department, W. A. T. A.

"Sociological Aspects", Miss Metta Bean, Social Service Department, W. A. T. A.

"An Age Group Comparison of Heart Disease and Tuberculosis", Dr. Louis M. Warfield, Milwaukee.

Discussion—"The Situation in Racine", Dr. W. W. Bauer, Commissioner of Health, Racine.

"Mental Hazards in the Cure of Tuberculosis", Dr. H. Douglas Singer, Professor of Neuro-Psychiatry, University of Illinois.

Discussion—Dr. Rock Sleyster, Medical Director, Milwaukee Sanitarium, Wauwatosa.

"Mental Factors in Sanatorium Care", Dr. J. W. Coon, Superintendent, River Pines Sanatorium, Stevens Point; Dr. G. L. Bellis, Superintendent Muirdale Sanatorium, Wauwatosa.

"The Mental State After Discharge from the Sanatorium", Mrs. Anna Thompson Grover, Milwaukee.

Two new directors were the only new officers elected. The new directors are Quincy Hale, La Crosse, and Dr. M. S. Hosmer, Ashland. Reelected officers include Dr. C. H. Stoddard, Milwaukee, president; Dr. J. Gurney Taylor, recording secretary; and Drs. J. W. Coon, Stevens Point; Wilson Cunningham, Platteville, and G. Windesheim, Kenosha, directors.

NEWS ITEMS AND PERSONALS

Dr. William J. Meier, eye, ear, nose and throat specialist from Chicago has rented an office in the Van Zanten Medical Building at Sheboygan.

—△—

Dr. Sarah I. Morris has accepted a position as director of the Health Clinic for the Woman's Medical College of Pennsylvania. This clinic will have general charge of student health and feature periodic health examinations for the undergraduate body. Dr. Morris has been a member of the faculty of the School of Medicine and of the student health service of the University of Wisconsin for twenty years.

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Dr. Ralph G. Mills of the Wylie–Smith Clinic, Fond du Lac, addressed the members of the Fox River Valley Funeral Directors' and Embalmers' Association at a meeting in October. He discussed anatomy as it pertains to embalming.

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Dr. and Mrs. H. E. Twohig, Fond du Lac, and their two daughters returned on October 28th from a nine weeks' tour of England, Belgium, France, Switzerland, Austria, Hungary, and Germany. They also made an extensive trip by automobile through the southern section of Ireland.

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Plans for the construction of a children's hospital unit at Sunnyview Sanatorium, maintained jointly by Fond du Lac and Winnebago counties, have been approved by the board of trustees. The structure is expected to cost nearly $30,000 and will consist of a two-story addition.

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Dr. Robert Krohn, formerly of Grand View Hospital, La Crosse, is presently in Chicago doing postgraduate work. After January first he will be in practice as a member of the Krohn Clinic in Black River Falls.

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Dr. W. W. Kelly, president of the Green Bay Board of Education, was appointed by Governor La Follette as a member of the George Washington Bicentennial Commission for the State of Wisconsin. The George Washington Bicentennial celebration begins on February 22nd and there are 22 members on each state commission. It marks the 200th anniversary of the first president's birthday. The celebration which will center largely in Virginia and Washington, D. C., will extend to every state and city. It will continue until the autumn of next year.

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Dr. W. D. Stovall, director of the state laboratory of hygiene, Madison, was speaker at the opening meeting of the Twilight Club, at Janesville, November 10th. He spoke on "The Influence of Science In Education on the Progress of Medical Practice."

Dr. D. H. Eurit of Otterbein, Indiana, has assumed the practice of Dr. T. M. Slemmons of Argyle who left there to take special work.

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Dr. Harry B. Moe, who has been associated with the Munn–Farnsworth Clinic in Janesville the past year, has opened an office for individual practice at 421 Hayes Blk., Janesville.

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Some of the irregularities of the human body was the subject of an address by Dr. Arnold Jackson, Madison, before a Gyro Club meeting in the Loraine Hotel.

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Dr. A. B. Leigh, Kaukauna, gave a talk to the high school football squad on the use of the ultraviolet ray machine recently purchased by the school, and on the treatment of injuries, sores, and bruises suffered by football players. Chalk illustrations of the various phases were given throughout the talk.

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Dr. Robert T. McCarty, a graduate of Marquette University School of Medicine, in 1931, opened offices on the sixth floor of the new Zuelke building at Appleton. He served his internship at Milwaukee County hospital. Since last June he has assisted Dr. G. J. Flanagan at Kaukauna and Dr. W. E. Archer of Dale.

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Dr. J. B. MacLaren of Appleton attended the annual meeting of the American College of Physicians and Surgeons held in New York City in October.

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Dr. J. D. Walsh, a recent graduate of the University of Wisconsin Medical School, purchased the practice of Dr. F. P. Daly of Reedsburg. Dr. Walsh was former resident physician of Milwaukee County Hospital.

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Dr. George H. Ewell of the Jackson Clinic, Madison, presented a paper before the north central branch of the Urological Association at St. Paul.

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Dr. and Mrs. E. D. Sorenson of Elkhorn have been entertaining at dinners with the wild duck and pheasant which the Doctor brought back from his hunting trip to North Dakota.

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Dr. H. A. Raube of Beloit addressed a meeting of the Beloit Graduate Nurses Club. His topic was "European Clinics as Seen by American Physicians."

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Dr. John George Moss, a graduate of the University of Minnesota Medical School in 1930, has opened offices in the postoffice building at Denmark.

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Dr. G. W. Henika, assistant state health officer, Madison, spoke on "Infantile Paralysis" before a meeting of the Black Earth and Vermont Lutheran brotherhoods at the Vermont Lutheran Church in November.

Dr. Joseph C. Springberg has opened an office for the general practice of medicine and surgery in South Wayne, LaFayette County. He is a graduate of the University of Wisconsin Medical School in 1930.

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Dr. Agnar T. Smedal, son of former Sheriff H. A. Smedal of Dane County, is practicing medicine in Madison with offices in the Tenney Building. He is a graduate of Rush Medical College in 1929 and spent three years in Los Angeles County Hospital.

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Dr. F. E. Kosanke, Fond du Lac, who has practiced medicine in that city since 1927 has removed his office to Lomira, a suburb of Fond du Lac.

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Fracture cases treated during the month of October were discussed by thirty members of Mercy hospital, Janesville, staff meeting at the hospital. X-ray pictures were used to illustrate the cases. Dr. A. H. Pember, president of the staff, conducted the business session following a six-thirty o'clock dinner.

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Members of Outagamie County Medical Society entertained Outagamie county lawyers at a turkey dinner on November 10th,—the result of the lawyers' victory in a golf match last summer. It was estimated that more than sixty persons attended.

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An auxiliary unit of the State Laboratory of Hygiene has been recently established in Sheboygan, with Miss Elizabeth Mathewson, for the past year a member of the central laboratory staff in Madison, in charge of the laboratory. It is financed jointly by the city and state.

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MILWAUKEE

Following a number of meetings with the Child Welfare and Public Nursing Committee in regard to complaints which have from time to time been lodged against health department nurses by the medical profession, Dr. John P. Koehler, Milwaukee Health Commissioner, has laid down new rules for health department nurses. It is hoped by the Committee that these new rules will bring about a much more satisfactory relationship between physicians and nurses, and make closer cooperation with the health department possible.

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The DeLonge Studio has made up a portrait register of members of The Medical Society of Milwaukee County. This undoubtedly will prove exceedingly valuable as a record, from a historical point of view.

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The nominating committee, recently appointed by Dr. E. L. Tharinger, president of The Medical Society of Milwaukee County, and approved by the board of directors, consists of the following physicians: Drs. R. W. Blumenthal, chairman; H. S.

Roby, L. F. Jermain, J. C. Griffith, Dexter Witte, N. E. McBeath, Edward Jackson, E. L. Baum, and George Neilson.

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The following members have appeared for the Speakers' Bureau of the Medical Society of Milwaukee County during the past month:

On October 26th, Dr. D. W. Roberts gave a talk before the Twentieth Century Topic Club of Wauwatosa. His subject was "How Is Your Health?"

Dr. Carl W. Eberbach addressed the parent-teacher organization of the Hopkins Street School on November 12th on the subject of "The Goiter Problem in the Great Lakes District."

At a luncheon meeting of the Co-Operative Club on November 14, Dr. Louis Warfield addressed the members on "What You Should Know About Your Heart."

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Mrs. Maude S. Curtin, wife of Dr. A. L. Curtin, passed away at her home, 1943 N. Summit Avenue, November 9th, at the age of 37 years. She had been ill for a period of about three years. Mrs. Curtin was a former nurse, having come to Milwaukee sixteen years ago to finish her nurses' training in Mount Sinai Hospital.

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Dr. Morris Fishbein, editor of the Journal of the American Medical Association was a recent Milwaukee visitor. He came to address the Women's Club of Wisconsin.

Dr. Fishbein urged the immediate use of private hospitals for the care of World War veterans whom the Federal Government is unable to hospitalize because of overcrowded hospitals. Dr. Fishbein expressed himself as heartily approving the use of the many thousands of empty beds in private hospitals, due to the depression, for the veterans, for whom the United States Veterans' Bureau is engaging in an extensive program for the expansion of government hospitals.

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On September 28th, October 5th, October 12, and October 19, Dr. Francis D. Murphy, of the School of Medicine of Marquette University, broadcast over radio station WHAD on different phases of diabetes.

On Monday, October 20th, Dr. D. W. Roberts, also of the School of Medicine, Marquette University, broadcast over WHAD on the subject of "History of the Mentally Sick."

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On October 30th, Dr. George P. Barth, of the Milwaukee Health Department spoke at the Milwaukee Maternity Hospital. His subject was "Immunization, Natural and Acquired."

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Dr. E. V. Brumbaugh, of the Milwaukee Health Department, was the speaker at the radio forum, sponsored by the city council of parents and teachers, over radio station WTMJ, on October 28th. He discussed "What the Summer Health Round-up Means to the Community."

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Dr. Edwin B. Gute, health officer of Whitefish Bay, recently addressed the Richards Street School Parent-Teacher organization.

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At a meeting of the Mothercraft Class of the Maternity Hospital and Dispensary Association on November 6th, Dr. M. W. Sherwood spoke on "Social Diseases."

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Dr. and Mrs. Gilbert E. Seaman recently returned from a motor trip to Detroit.

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Dr. and Mrs. George A. Harlow enjoyed a ten-day trip in the East, during October.

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St. Mary's Nurses Alumnae Association held its annual dinner dance at the Hotel Schroeder on November 19th. The proceeds of the entertainment were given to charity.

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At the annual meeting of the Milwaukee League for the Hard of Hearing, held in June, Dr. Samuel G. Higgins was elected President. The guidance of an aurist is recommended for each local league by the National Federation of the Leagues for the Hard of Hearing.

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Dr. L. A. Van Ells recently returned from the East where he took a short postgraduate course at the Harvard Medical School in Traumatic Surgery.

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Three postgraduate medical courses, sponsored by the educational committee of The Medical Society of Milwaukee County, will be given for Society members this winter. The courses,—Diseases Of The Nervous System, Diseases Of The Heart, and Surgical Diagnosis Of The Abdomen,—are proving to be of great interest to members, and reservations are coming in daily in large numbers. The first course, Diseases Of The Nervous System, will be given the early part of December. All of these courses are to be conducted by local men, and are open to members free of charge.

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Considerable interest is being displayed in the request of The Medical Society of Milwaukee County that an emergency ambulance be placed at the Johnston Emergency Hospital. In a recent letter addressed to the common council, the Society informed that body that its board of directors objected to the inclusion in the 1932 budget for the city of Milwaukee of an appropriation for the establishment of an additional fire department rescue squad. The Society, through its board of directors, said that it felt that the services rendered by such squads, where medical attention was necessary, were not only inadequate but even dangerous without proper diagnosis and treatment by a physician, and requested that, for the best interests of the public, an

emergency ambulance, manned by trained physicians, be established.

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The Reverend William M. Magee, President of Marquette University, officially opened work October 2nd on the new school of medicine which, it is expected, will be completed in readiness for the 1932–1933 school year. Dr. Louis F. Jermain, Dean Emeritus of the School of Medicine, was present at the ceremony.

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Dr. E. L. Miloslavich, addressed the annual meeting of the Central Section of the American Association for the Advancement of Science, at Three Oaks, Michigan, on May 15, 1931, on the subject of "Human Polymastia". He spoke about the "State vs. George W. E. Perry Murder Case" at the meeting of the Blackstone Club, to which the Lawyers' Club was invited, on June 2.

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Dr. and Mrs. Otto H. Foerster announced the engagement of their daughter, Miss Frances Foerster, to Dr. Dean H. Echols, son of Dr. and Mrs. Chester M. Echols.

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A son was born to Dr. and Mrs. E. L. Martineau on November the sixth.

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Mrs. Selby V. I. Brown has been elected president of the Welfare Auxiliary of the Milwaukee Children's Hospital.

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Dr. S. A. Morton of the Mayo Clinic, Rochester, Minnesota, has been appointed radiologist of Columbia Hospital. His duties will begin on December the fifteenth.

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Dr. Francis D. Murphy addressed the Marquette University Faculty Wives at their meeting on November 17th, at the Knickerbocker Hotel. His subject was "Degenerative Diseases."

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Construction of the New Stark Hospital for Children, to be located adjacent to the Milwaukee Children's Hospital, is to begin at once. It will be under management separate from that of the Children's Hospital, but the two buildings will be connected by a tunnel, and will have cooperative and coordinated activities. The estimated cost of the building is $120,000.

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A series of Institutes in Maternity Nursing Service were held at Mount Sinai Hospital from November 16th to November 19th, inclusive. Miss Anita M. Jones, R. N., of the Maternity Center Association of New York City, conducted the institutes, which were sponsored by the fourth and fifth districts of Wisconsin State Nurses' Association and the Milwaukee League of Nursing Education. Miss Jeannette M. Hays is director at district headquarters.

Approximately 250 persons have registered with the Bureau of Registered Blood Donors which open the Bureau of Registered Blood Donors which opened November 11th. This central bureau will mitigate the loss of time in securing a blood donor in emergencies, and has guaranteed to furnish the correct type of donor to any Milwaukee hospital in need of such service. The Bureau, when only a week old, had sent out five donors.

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As this item goes to press Dr. Roland S. Cron, Milwaukee, is very seriously ill at Columbia Hospital, suffering from a blood infection which has been diagnosed as agranulocytosis, a rare blood disease. In addition to a group of Milwaukee physicians attending Dr. Cron, several specialists have been called in for consultation, among them Dr. Joseph Miller, Chicago, Dr. Leonard G. Rowntree, of the Mayo Clinic, Rochester, Minnesota, and Dr. William S. Middleton, of the University of Wisconsin College of Medicine.

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December the 19th has been set as the date of the wedding of Arthur A. Holbrook, son of Dr. and Mrs. Arthur T. Holbrook, to Miss Susan M. Dette, of Milton, Massachusetts.

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At the annual convention of the Catholic Family Protective Association of Wisconsin, held on November 18th, in Eau Claire, Dr. Henry J. Gramling, a director of The Medical Society of Milwaukee County, was elected medical director.

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Dr. Edmund H. Mensing will appear before the North Shore branch of the Chicago Medical Society at a meeting to be held at the Edgewater Beach Hotel, Chicago, on December first. His subject will be "The Clinical Side of Jejunal Feeding."

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Definite plans are being made for the first of a series of postgraduate courses, sponsored by the educational committee of The Medical Society of Milwaukee County, to be given during the winter months. "Diseases of The Nervous System," the subject of the first course, has proven of great interest to Society members and a large class is expected when the course opens on December first.

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Two Milwaukee physicians, Drs. C. W. Long and L. M. Warfield, suffered accidents during November. Both doctors are suffering with fractures of the foot.

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The program committee of the Medical staff of St. Mary's Hospital are trying out a new idea for their staff meetings. They are giving dry clinics in which the patients, either medical or surgical, are presented at the staff meeting whenever possible whether it be a pre-operative or post-operative surgical case to present the history and to have a general discussion of a subject on part of the men presenting the case as well as the other members of the staff. The first program of this type was given

on November 4th, and the following program presented:

"Case of Banti's Disease Following Splenectomy," Dr. John Klein.

"Case of Duodenal Ulcer with Obstruction," Dr. T. H. Rolfs.

"Two cases of Gastro-jejunal Ulcer," Drs. Weber and Wolters.

"Case of Solitary Polyp of the Sigmoid," Dr. Dexter Witte.

"Case of Duodenitis," Dr. Francis B. McMahon.

It was felt by the members of the staff that this departure is of a distinct advantage over the older methods of conducting staff programs, and future programs will be arranged along these same lines. It is feasible and practical to have extra-mural patients for clinical demonstration also.

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The following radio talks, sponsored by the State Board of Health and delivered by Mr. Theodore Wiprud, executive secretary of The Medical Society of Milwaukee County, will be broadcast over the Milwaukee Journal Radio Station, WTMJ, during the month of December:

December 4, "Defective Speech in Children"; December 11, "Those Troublesome Teens"; December 18, "Tonsils—In or Out?"; December 25, "Holiday Hygiene." The talks are broadcast from 2:15 to 2:30 P. M.

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Mrs. M. MacKedon, mother of Drs. William L. and T. E. MacKedon, passed away at her residence on November 14th.

—△—

Mr. Theodore Wiprud, executive secretary of The Medical Society of Milwaukee County, spoke before the Milwaukee County Dental Society at its regular monthly meeting on November 18th, at the Hotel Pfister. The subject under discussion was that of medical and dental economics.

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On November 12th, Dr. Carl W. Eberbach, speaking for the speakers' bureau of The Medical Society of Milwaukee County, addressed the Parent–Teacher Association of the Hopkins Street School on "The Goitre Problem in The Great Lakes District."

BIRTHS

A daughter to Dr. and Mrs. Arnold S. Jackson, Madison, November 3rd.

MARRIAGES

Dr. Vincent W. Koch, Janesville, to Miss Ardelia R. Olden of Norwood, Pa., at Norwood, October 30th.

DEATHS

Dr. Edward G. Higgins, Melrose, died at St. Mary's Hospital, Rochester, Minnesota, on October 29th. Following two major operations in the past four months, favorable reports of his condition had been received until the day before his death.

Dr. Higgins was born in Stevens Point, January 26, 1876. He was a graduate of Milwaukee Medical College in 1904 and immediately began the practice of medicine in Melrose in partnership with another physician. For many years Dr. Higgins had been carrying on his practice alone. He was vice-president of the Bank of Melrose and was a charter member of the Melrose Rotary club, also serving as its president.

Dr. Higgins was a member of Trempealeau–Jackson–Buffalo County Medical Society, the State Medical Society and the American Medical Association.

He is survived by his widow.

Dr. W. T. Sarles, Sparta, President of the State Medical Society of Wisconsin in 1900, died on October 31, 1931, at his home following an illness of eight years.

Dr. Sarles was born in Armenia, Juneau County, November 14, 1856. He attended River Falls Normal school and Galesville University. He then entered the office of Drs. Gage and Beebe in Sparta, where he studied medicine for a time, later attending Rush Medical College graduating in 1882. He also attended lectures for a term at Jefferson Medical College in Philadelphia.

Upon returning to Sparta, be became the junior member of the firm Gage, Beebe and Sarles, and for some time was senior member of the Sparta Clinic until eight years ago when ill health forced him to give up active work.

For some time he was physician for the Chicago and Northwestern railroad at Sparta and for fifteen years served as president of the State Medical Board. He was a former president of the National Association of Railway Surgeons and for many years was a trustee of the American Medical Association.

He was elected mayor of Sparta for three consecutive terms and previous to that time was city health officer for ten years. While mayor he was influential in having the city water works and electric lighting system installed. For 25 years he was a member of the United States Pension Examiner's Board, serving as secretary for a long term of years.

He served as delegate from the seventh district to the Republican Convention held in Chicago, which nominated Theodore Roosevelt in 1904, and four years later was an elector for William H. Taft from the same district.

Dr. Sarles was a member of the Monroe County Medical Society, the State Medical Society, and was a fellow of the American Medical Association.

He was buried in Woodlawn cemetery, Sparta, with Masonic honors.

Dr. Sarles is survived by his widow and two daughters.

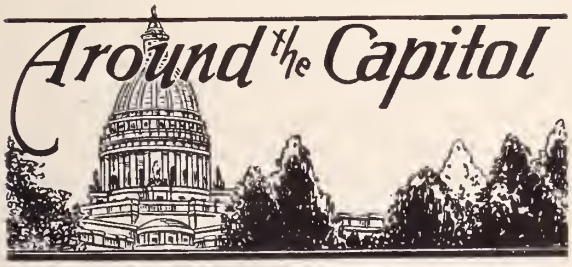
SOCIETY RECORDS

New Members

M. E. Nesbit, 1 South Pinckney St., Madison.
K. F. Prefontaine, Box 208, Slinger.
Wm. R. Kennedy, 606 W. Wisconsin Ave., Milwaukee.
J. K. Shumate, Pureair Sanatorium, Bayfield.
A. D. Campbell, Richland Center.
Karl Icks, Green Bay.
G. J. Warnshuis, Cedarburg.
Armin Steckler, 7139 W. Greenfield Ave., West Allis.
R. J. Bach, 312 E. Wisconsin Ave., Milwaukee.
A. J. Randall, 6225—2nd Ave., Kenosha.

Changes in Address

Wm. M. Sproul, Wauwatosa to Polyclinic Hospital, Des Moines, Iowa.
J. L. Rens, Loretta, to Lugerville.
M. R. French, Albany, N. Y., to Elsmer, N. Y.
P. M. Kauth, Slinger, to West Bend.
C. W. Rice, Delavan, to Monroe Center, Ill.



While the prevalence of infantile paralysis in Wisconsin during the first three quarters of 1931 reached the epidemic stage and exceeded the number of cases in any previous years, the percentage of deaths from this cause was the lowest on record.

The state bureau of communicable diseases said that 555 cases were reported but there were only 37 deaths from January to September, establishing a record of less than seven per cent for cases that resulted fatally. In 1916 when the disease attained the form of an epidemic there were 465 cases and 16 per cent resulted fatally.

* * *

More than 6,000 persons died of heart disease in Wisconsin during 1930, according to the statistics of the state board of health. Of the fatalities, 3,344 were men and 2,737 women.

* * *

Expenditure of $219,000 for buildings at the Mendota State hospital and Farwell's Point Memorial hospital is planned by the state board of control if the special session of the legislature will approve the funds.

Of this amount, $194,000 would be spent at Mendota hospital for construction of a receiving building, occupational therapy building, laundry and a physician's residence. At the Farwell Point institution, a $25,000 residence would be constructed.

* * *

Leading death causes in the fifteen age groups of Wisconsin's population are premature birth for the group below a year in age; pneumonia proved the leading death cause among children from one to five years; accidents between five and nineteen years; tuberculosis was the principal cause of death between the ages twenty and thirty-nine; and after forty years of age heart disease supplants tuberculosis as the leading menace to life, the records of the bureau of vital statistics show.

* * *

Prediction that man's average life is about to be increased to 70 years was made at the American College of Surgeons' meeting by Dr. Charles H. Mayo, Rochester, Minnesota. "The average expectation of life is now 58 years," he said. "Within 25 years it is my belief this expectation should be advanced to 70 years. The added span will come about through education, teaching people that they must care for themselves and how to do it."

» » » CORRESPONDENCE « « «

"WITHOUT JUST PROVOCATION"

Editor of Wisconsin Medical Journal
Dear Sir:

During this time of social, political and economical unrest, it is to be expected that the source will be sought and exploited by the public.

Thus far "the high cost of being sick" seems to have occupied the minds of most of the literary aspirants, to the entire exclusion of "the high cost of being well", "the high cost of legal advice and protection", "the high cost of the abuses of state institutional privileges" of political factions and maintaining their advocates, "the high cost of establishing and maintaining the government and state institutions thus far created for the care of indigent sick people", "the high cost of maintaining any politically controlled institution," and the many more really pertinent high costs which might be elaborated upon by literary experts.

If the public's mind is allowed to dwell on this one exploited subject it is to be expected that legislation will be demanded and enacted by vote seeking hungry politicians.

I was very much interested in listening to and reading Dr. Fiedler's article as published in the October Wisconsin Medical Journal. It is true that this is about the only country in which the medical profession still maintains a semblance of having the ability to manage its own affairs and work out

its own problems and developments, but so far as history teaches, America has never looked for other countries to pattern after, and from my own knowledge acquired from interviews with physicians in London the medical profession situation in England is deplorable.

President Glenn Frank's exhortation does not apply to America, for our people have always had the best the medical profession could give at a price commensurate with the ability of the patient to pay, and if the patient could pay nothing they received the same care.

Practically all the agitation is without just provocation and I do not feel that the medical profession of America should lay down its arms and sacrifice its individuality and independence without a struggle, and by a struggle I mean united concentrated action directed at our legislators to show them that the present system is superior to any other adopted by other countries. This can be brought to their attention on a very substantial business basis showing efficiency and economy. The tax burden is the vulnerable approach to the public and legislature.

Other "high costs" should be brought to the public's notice in an effort to detract attention from "the high cost of being sick".

Dr. Fiedler's article would indicate in its closing paragraph that social medicine is in successful operation in almost every other industrial nation. This is not true as can easily be determined by interviewing the doctors in other countries. I do not mean an interview with the few select who are selling their services to insurance companies or the state at the expense of their professions and colleagues, but, an interview with the general mass of physicians in those countries where state medicine is administered.

Red-blooded American physicians would not endure such conditions as exist there. Socialistic and communistic ideas are too often expressed in our state governmental circles under the guise of "republican administration" and I am convinced that it will not be long until a violent reaction will occur which will rid this state and other states of socialistic and communistic propaganda and with it will go the propaganda of social medicine.

Social medicine cannot be practiced without the consent of the medical profession. I think the time is nearly ripe for the A. M. A. to let its stand be known to our communistically inclined governmental friends and in such a way that they will not misunderstand.

Quacks and patent medicines which annually cost our people so much can be eliminated as easily under our present form of government, as they can under any other. A few men can always be bought to work in state hospitals, etc., and these men are called upon too often to lecture and read papers at our state medical meetings but they are not the men who are upholding the principles and glory of our grand and noble profession. They are working, as any other laborer, for money and they are not the men who are serving the masses of humanity and giving the best that is in the profession.

I maintain that the American physicians give the people of America the best service in the world and at a price commensurate with their ability to pay, and before permitting a changed policy let us ascertain if that is not true and if it is true let the people know it instead of taking quietly what politicians see fit to hand us.

I do not know that it will be possible to get this or similar articles into our state journal but I would like to see something printed on the red-blooded side of the sheet.

Yours truly,
ARTHUR J. BATTY, M. D.

Portage, Wis.

SERVICES OF ASSISTING SURGEON

14 November 1931.

State Medical Society,
Washington Building,
Madison,
Wisconsin.
Att'n: *Mr. J. G. Crownhart.*
Dear Mr. Crownhart:

You referred to us letters from two members of your society which present the following situation upon which you asked us to render you an opinion.

In an operation in which two surgeons are involved, one assisting the other, it appears that the patient, who had had considerable hospital experience, refuses to pay the bill of the assistant surgeon because he, the patient, was not specifically notified before the operation that such assistant surgeon would be required.

It further appears that the patient, a minor, had consulted the major surgeon several times, and the patient contends that specific sums were named by the major surgeon within which the expense of the operation would range. This is contradicted by the major surgeon who insists that no statement regarding the costs and the expense of the operation had been made by him for this particular case. The operation involved a retrocaecal ruptured appendix with a local abscess present which presented a far more difficult operation than simple appendectomy. Even if some conversation had ensued between the patient and the surgeons in regard to the expense of such an operation, it could not be assumed that such a statement would bind the surgeon in the complex situation found here, according to the surgeons involved.

It further appears at the time of the operation that the patient's attention was called to the assistant surgeon and the fact that he was to assist in the operation. The patient was conscious, being operated upon under a spinal anesthesia, until the last ten minutes of the operation. The surgeons both contend that the patient's father knew that the two worked together on any case and that he was,

therefore, impressed with the responsibility of paying each of them individually.

The problem here presented must necessarily be approached from two angles:

(1) Does the ordinary contract between a surgeon and a patient authorize the surgeon to employ an assistant surgeon at the patient's expense?

(2) Because of the particular circumstances found in this case, can it be said that here the contract implied such authority?

A contract between a surgeon and a patient where the patient specifically authorizes certain services becomes an expressed contract even though the amount to be paid is not specifically settled. Where the contract is expressed, as here, it appears to be the majority rule of the courts that a physician has no authority, beyond that which is expressed or is necessarily implied, to employ others as assistants. Thus, it has been held that a physician may recover for the services of his student assistants. See 48 C. J. 1162, Paragraph 180, and cases cited. However, it is further held that a physician has no implied authority to employ others to assist him in giving treatment or even to order the patient's removal to a hospital. See *Johnson vs. Roberts*, 212 Ala. 535, and *Medlin vs. Bloom*, 230 Mass 201. In the case of *Johnson vs. Roberts*, cited supra, an employee of a corporation suffered serious injury to his foot. The physician was employed "to do everything necessary and not to leave a stone unturned." The physician himself was unable to accomplish satisfactory results and called in another to help him. The court held that the authorization given to the first surgeon did not authorize him to call in another. In the case of *Webb vs. Porto Rico American Tobacco Company*, 16 P. R. 378, 388, the court said "it can never be understood that the mere fact of entrusting the care of a patient to a physician includes the power to call another physician to assist him".

In the case of *Linsay vs. Freda*, 56 N. S. 210, the physician called in two assistants, but the patient had authorized the employment of only one assistant. It was held in that case that the patient was not liable for the unauthorized employment of the second assistant.

It would seem to be the general rule from the cases cited supra that the services which a patient engages when he contracts for an operation are primarily those of the surgeon, and that because of the personal nature of such services, the courts will not construe the contract to include others than such surgeon. The question now arises as to whether the circumstances of this particular case would hold that the major surgeon was impliedly authorized to employ an assistant. The patient and his father both assert that they had no notification that such an assistant would be required, but the surgeons involved contend that the practice in that particular locality had become a custom to engage an assistant and that bills were always rendered separately for the services of each. They contend that the patient and his father knew this custom and also knew that the two particular surgeons here involved always worked together.

However that may be, custom may be shown only for the purpose of interpreting the provisions of a contract, and it seems doubtful here that evidence of the custom of physicians would be sufficient to bind the patient for the services of both the major and assistant surgeon. The question would rather seem to rest not upon custom but upon knowledge of the patient, or in this case of his father, that an assistant would be required. If it can be shown that there was such knowledge here, it would seem that the patient would be bound to pay the services of the assistant surgeon. In the case of *Garrey vs. Stadler*, 67 Wis. 512, where a consulting surgeon had, at the request of an attending surgeon, rendered certain services to a patient with his consent and knowledge, it was held that the consulting surgeon could recover the value of such services from the patient despite an agreement between the patient and the attending surgeon that the latter was to pay for such services provided that the consulting surgeon neither expressly nor impliedly consented to such an arrangement.

It is our conclusion, therefore, that the bill of the assistant surgeon is not collectable unless it can be clearly shown that the patient or his father knew that such services were to be rendered. A situation such as this need not arise if the operating surgeon would clearly notify the patient in advance that such services would be required. But, since this was not done here, we believe that it would be extremely difficult to prove knowledge on the part of the patient or his father. While the bill is undoubtedly morally due the assistant surgeon, we consider it improbable that he will be able to enforce collection of the same.

Very truly yours,

Legal Counsel.

THE POTTS' ARTICLE

Drs. P. A. Hoffmann & Son

Campbellsport, Wisconsin

Oct. 28, 1931.

Mr. Geo. J. Crownhart,
Madison, Wis.
Dear George:

Permit me to voice my weak protest to the President's Address as published in our October Journal. We should unite with all means at our command to oppose any further encroachment of this doctrine of communism on physicians and patients alike.

Please advise if the Bulletin of the American Medical Association reaches all doctors in the state. If not could it be arranged that each doctor receive it? Everyone should read in it the article by Dr. Potts describing Socialized Medicine in Germany.

Leo A. Hoffmann.

BASIC BOARD MEETS DEC. 19TH

STATE BOARD OF EXAMINERS
In the Basic Sciences

Madison, Wisconsin, October 20th, 1931.

Wisconsin Medical Journal,
Madison, Wisconsin.

Gentlemen:

The next examination by the Wisconsin State Board of Examiners in the Basic Sciences will be held on December 19th, 1931, at the Hotel Pfister, Milwaukee, Wis.

Application to be made to Robert N. Bauer, secretary, 3414 W. Wisconsin Ave., Milwaukee, Wis.

Very truly yours,
ROBERT N. BAUER,
Secretary, Basic Science Board,
3414 W. Wisconsin Ave.,
Milwaukee, Wis.

Shall Hospitals Be Exempt from the Proposed Eight Hour Day Law?*

By J. G. CROWNHART
Secretary Wisconsin Hospital Association and
State Medical Society of Wisconsin
Madison

Concerned with the subject of unemployment and charged with the duty presently to bring before the special session this fall a bill designed to check its advances, this committee is considering a bill to provide that all employers shall institute an eight hour day or pay a substantial additional amount for overtime.

Sympathetic with the aims of your committee, I present the peculiar problems that this offers as it concerns the private hospitals of the state. And by the term "private hospitals" I refer to all that are not owned by the state, a county or political subdivision.

Those who care for the sick and injured have entered upon an unusual occupation. There are no economic laws governing demand for their services. The physician, nurse or hospital may encounter a peak load, not for a month, a season or a year, but today, and be faced with it within a matter of less than an hour. Care of the sick requires a trained personnel and team work to the highest degree. No emergency makes such demands as the emergencies that arise from illness. "Overtime" to meet such public needs is one of the professional obligations of any person or institution that treats the sick.

A hospital is a distinct community asset and yet of the 125 private hospitals of this state I know of but two or three where they maintain themselves on income. They are but the outstanding exceptions that prove the rule that hospitals are universally dependent for their very existence upon donations or endowments from the charitably inclined of the community. In times of economic pressure, such as we face presently, this income from charity decreases and at the same time the charitable work that the hospital is called upon to meet increases.

The costs of illness concern not only the Wisconsin Hospital Association but the State Medical Society, the state organization of nurses and all who are interested to the end that the best that scientific medicine has to offer be available to all, regardless of station in life, at a cost that is within their abilities to meet. And to all of us who are seeking constantly to improve the availability of service it is impressed upon us at the outset that the costs of illness so frequently fall at a time when people are least able to pay. Thus the wage earner who becomes ill not only loses his income but is at the same time confronted with the added costs of illness.

The hospitals of this state, gentlemen, are not concerned with your legislative proposals in the sense of proprietary owners. Their only holdings may be said to be those of a public responsibility. Their dividends are in terms of service. Their stockholders are the people of the community. Their only concern here is that you fully appreciate what harm might result from this legislation.

At no little expense it has been my privilege to have made a survey of the hospital facilities of this state with particular refer-

* Summary of remarks before the Interim Committee on Unemployment created by the 1931 Wisconsin Legislature, at Madison, Oct. 13, 1931.

ence to the financial conditions and employment situations. The 125 private hospitals have a capacity of 10,714 beds and bassinets. The average occupancy appears to be in the neighborhood of 62% and it appears that from 18% to 25% of that occupancy is charity work.

I venture the prediction that if the economic pressure continues the hospitals will have a falling percentage of occupancy, —not from the poor but from that class of people who ordinarily would think nothing of going to the hospital when ill, but with the present psychology are under the impression that perhaps they would do well to stay at home. Recent conversations with relatives of the ill among what one might term fairly well-to-do people convince me that this is taking place every day. Thus will the hospitals gradually lose other revenue that normally helps to support the institution as a whole.

While our survey shows notable exceptions, perhaps it will be the small and medium sized hospital that will be hardest hit. Yet they are located in communities where they stand alone and where as a community asset their services are without price or value.

It has been suggested that instead of increasing costs, an eight hour day law applied to hospitals as well as to industry, would only result in reducing the present wage level and affording additional occupation to presently unemployed. It is to be remembered, however, that the peak load of the hospital comes at intervals that have no regularity. Even one automobile accident case can detain the operating room team, kitchen, and maid service as well as the scrub woman. Extra help cannot be employed where there is no regularity in need nor can trained help be secured on short notice.

Hospitals have no efficient means or setup for figuring overtime except that in a general way they make an effort to pay back overtime service today with extra time off (always subject to call) when the load is lighter. Again, I think this committee will find that the wages of hospital attendants and untrained help are not far above the minimum wage standards and that any reduction in wages of sufficient consequence to enable employment of additional help without increased expense will work a severe hardship on present employees.

When we consider the eight hour day proposals as they would affect nurses we are at once struck with a peculiar situation that would exist. Inasmuch as employers of three or less would be exempted, we would exempt the private duty nurse whose usual tour of duty is at least twelve and generally twenty hours. Thus a private surgical case might employ a twenty hour nurse and yet the hospital in which she worked could only employ a nurse for eight hours without paying overtime.

It is true, I am convinced, that hospitals have long been working towards an eight hour basis. That they have special and unique problems is attested by exemptions from other legislation presently in force. I am convinced that again this is an instance where consideration of the peculiar problems of the hospitals warrants an exemption from any law you may propose limiting hours of labor as a means of furthering employment.

A survey of the institutions in the state where their accounting systems are very accurate shows that the costs for overtime work on a time and a half basis for over eight hours, would approximate $601,000 a year for all private hospitals in the state. We do not believe that this can be reduced by lowering wages of present help and employing others and that even if it were possible, it would not be in the best interests of the people the hospitals serve, to attempt it by some early legislative enactment. We believe that any added costs at this particular time will have to fall on the patient,—he who is already least able to pay. And some superintendents tell me that their financial problems are already so great that any additional burden over the presently greatly increased charity problem might even necessitate closing the institutions.

We present this to you, gentlemen, not as our problem but yours. Hospitals are great community assets; rarely are they institutions for profit, and the depression has given them tremendous financial problems. They present their problem to you confident that you will appreciate its serious nature.

I shall be happy now to answer any questions, Mr. Chairman.

DISCUSSION

Senator P. J. Smith (Eau Claire): Isn't it true, Mr. Crownhart, that in the last five years hospitals have doubled and tripled their prices?

Mr. Crownhart: No, Senator, you will find that not only is that not true but that their costs have lagged behind that of almost everything else. We must remember, Senator, that the hospital is not only a hotel run on the American plan but, in addition to all that, they must furnish all the equipment, attendants, skilled personnel and facilities that an advanced medical and surgical science has made essential. Withal, I think you will find that the average cost per bed in Wisconsin is in the immediate neighborhood of $4.20. Certainly that is far from excessive.

Assemblyman W. E. Burtis (Beaver Dam): If we had an eight hour day by instituting a fifty-four hour week, would not that solve your difficulties, Mr. Crownhart?

Mr. Crownhart: In a small part, Mr. Burtis. But far from any extent that would at all solve the problem we present.

Chairman (Senator) Anton Miller (Kaukauna): Any other questions?

Mr. J. J. Handley, Secretary, Wisconsin Federation of Labor (Milwaukee): How do you justify, Mr. Crownhart, a $100 a week bill at a sanitarium?

Mr. Crownhart: I do not know the case, Mr. Handley.

Mr. Handley: Well, these sanitariums were here at our last hearing.

Mr. Crownhart: I presume you refer to the representative of Sacred Heart Sanitarium who appeared with me at the hearing during the regular session. I can only say, Mr. Handley, that in my presentation here today I hold no brief for any one institution. I am trying but to present the problems that are common to all. It has been said that some hospitals in the state are poorly managed. Let us even grant that but still it would not change the situation that we have to face here today. I am confident that those changes that you would like to see brought about will come about in the immediate future, without law, and as fast as can be made commensurate with a high standard of service.

Assemblyman Harold Groves (Madison): Is there unemployment among nurses?

Mr. Crownhart: Yes, there is. But because it is largely among the private duty nurses whose employment is always irregular, its extent is hard to estimate. Miss Eldridge of the State Bureau of Nursing Education says that there is an unemployment problem but does not suggest eight hour day legislation as its remedy.

Chairman Miller: Any other questions?

Mr. Crownhart: Thank you, gentlemen.

Proceedings of the House of Delegates, State Medical Society of Wisconsin, Madison, September 8-10, 1931

TUESDAY EVENING SESSION

September 8, 1931

The meeting of the House of Delegates, Ninetieth Anniversary Meeting of the State Medical Society of Wisconsin, was called to order at seven-thirty p. m. in the Memorial Union Building, Madison, Wisconsin, by Dr. W. D. Stovall, of Madison, the Speaker.

Speaker Stovall: You will please come to order, gentlemen. In order to facilitate the business of the delegates of this house, it is necessary for the Speaker to appoint reference committees. The appointees of these committees have been notified, and I shall read them now.

Credentials

C. W. Henney, Portage, Chairman.
E. P. Crosby, Stevens Point.
C. F. Peterson, Independence.

Resolutions

Gunnar Gundersen, La Crosse, Chairman.
S. M. B. Smith, Wausau.
A. E. Winter, Tomah.
H. J. Irwin, Baraboo.
H. J. Gramling, Milwaukee.

Standing Committees (Committee on)

C. D. Boyd, Kaukauna.
R. M. Carter, Green Bay.
F. C. Kinsman, Eau Claire.

Reports of Officers

F. A. Thompson, Milwaukee, Chairman.
A. J. Wiesender, Berlin.
E. H. Spiegelberg, Boscobel.

These committees will have their reports ready for tomorrow's meeting of the House of Delegates.

You men who are assembled here this evening are the delegates of the County Medical Societies which comprise the organization of the State Medical Society of Wisconsin. You represent the interests of the physicians who are members of your Society. Your society not only represents the interests of the physicians of your community, but safeguards medical practice and the public who are dependent upon the physicians of your community for medical service. It, therefore, behooves you, in this assembly, to take seriously your obligation to represent your Society. Be sure that the State Medical Society reflects the opinion and the ideals of the component medical societies of this state.

For that purpose, every person here, as a delegate, has not only a right but an obligation to ex-

press himself freely on the subjects that are discussed before this body. I hope, therefore, that no delegate will feel that he is too young in the organization to get up and express what he believes to be the ideas of the Society from which he comes. It is only in that way that this Society can really be a State Medical Society and represent the physicians of this state. So I hope you will consider it not only a privilege but a duty to take the deliberations and considerations in this House as part of your obligation to the county from which you come, and discuss freely all subjects which come before the House.

The Committee on Credentials, Dr. C. W. Henney, Chairman, will now report.

Dr. Henney: There have been thirty-two delegates, seven alternates, and fifteen officers registered at the registration desk. In addition, a further check on the attendance is being made by the House of Delegates slips.

I move you that the attendance as so compiled constitutes the roll call of this house.

. . . The motion was seconded by Dr. Thompson, of Milwaukee, and carried . . .

Speaker Stovall: The Speaker will entertain a motion to approve the minutes of the 1930 meeting of the House of Delegates, as printed in the Wisconsin Medical Journal.

Dr. Wenstrand: I so move.

. . . The motion was seconded by Dr. Pope of Racine and carried . . .

Speaker Stovall: Reports of Officers and Committees. These reports have been printed in the Journal. I think, however, it is important that the chairmen of these committees and these officers, at this time, emphasize those parts of their report which they think are important and those parts which should be discussed. For that reason, I will ask Dr. Rogers, Chairman of the Council, to make his report.

Dr. A. W. Rogers: Mr. Speaker, as the Chairman stated, the report of the Chairman of the Council was printed in the Journal, and if there are any questions concerning the report, I shall be very happy to answer them. The Council, this afternoon, had an all afternoon session, and it seemed advisable to propose to you an amendment to the By-Laws which incorporates the identical wording on each membership application blank. The following is the amendment:

Amend Chapter IX of the By-Laws of the State Medical Society of Wisconsin, by adding a new paragraph to read:

"No member shall profess adherence or give support to any exclusive dogma, sect, or school."

Speaker Stovall: You have heard the report of the Chairman, with the suggested amendment to the by-laws. These alterations will lay on the table for consideration at tomorrow afternoon's session.

Secretary Crownhart: So you may all understand the proposed amendment, I shall read it again. (Secretary Crownhart re-read the amendment)

Speaker Stovall: This amendment will be taken up for consideration tomorrow afternoon.

We will next have the Secretary's report.

Secretary Crownhart: The Secretary's report was published, in some detail, in the Journal, and in the report of the Chairman of the Council a compilation was made in great detail as to how your funds are being used, as budgeted by the Council.

I hope, Mr. Speaker, if there are any members present, delegates or alternates or officers, who have any questions to ask, they will not hestitate to do so, for it is obviously impossible to go into great detail in the printed columns as to how the money is used, and we try to use such brief language as will indicate, in a general way, the disposal of the funds.

I shall be happy to have any questions at this time, Mr. Speaker, if there are any. If not, you will be interested to know the grand total of membership for the complete year, last year, was exactly 2,200, and that to date we have 2,022, with thirty some applications pending, which indicates any loss of membership will be less than one hundred, in spite of conditions as they are and despite an increase in dues.

The Secretary's report, as a whole, was published in the Journal, and I do not wish to take the time here, Mr. Speaker, to discuss it in detail, but rather to take this opportunity to present a special report.

To the 1931 House of Delegates:

Frequent appraisals of work accomplished, frequent consideration of basic principles and earnest thought to the problems that confront us, are fundamental to the proper development of your Society. In the published report before you, every effort has been made to these ends. In the desire earnestly to discharge the duty of Secretary of your Society, each year brings not only its new problems, but new light on old conditions.

The State of Wisconsin General Hospital at Madison is not a new institution. During the past few months, however, one component society and several members, have asked for information to which they are entitled. Because it is the thought of your Secretary that this new information will be of interest to all members, his report is made to this House of Delegates.

Three classes of patients are received at the State Hospital. First, we have the charity cases who are admitted upon the recommendation of a physician by certificate of the County Judge. Cost of care is borne equally by state and county except that the county must arrange all costs involved in transportation of the patient. Second is the so-called clinic case, received at a cost rate of $5 a day, upon statement of a physician that the patient can pay this hospitalization fee but that a medical fee in addition would be a real hardship. Third is the private patient, hospitalized in one of thirty-two beds af-

forded by the hospital for its medical and surgical staff.

I venture to say that there will always be a percentage of error in the classification of patients in any hospital. Rightfully, however, we may ask, as have members in this instance, if proper precautions are taken to the end that such percentage of error be maintained at a minimum.

Within the past year the Hospital has secured the services of a trained personnel whose endeavor it is to ascertain the financial status of the patient that each may receive the after care needed. Such services should tend to maintain any percentage of error at the lowest possible figure. Again, the state case is sent upon certification of the County Judge. The patient swears to the statement that he is without the means essential to his care. Generally the town chairman has noted his approval upon the application. A local physician has examined the patient and has certified it as a proper case for care at Madison, as differentiated from care at home under the new law obtained this year by your State Society. If the patient has concealed any assets the county may later institute suit for collection of costs and the patient is subject to arrest for false swearing. Under such precautionary measures it would seem that percentage of error should be a minimum. No complaints to the contrary have been received during the past year.

The clinic case, with the exception of some few emergency cases arising in the main out of accidents, such as are received at all hospitals, is accepted as such upon the written request of a physician. The physician is justified in making such a request if the patient can probably receive necessary care at Madison for which he is able to pay $5 a day flat rate hospital cost but to whom a medical or surgical fee, in addition, would be a real financial hardship.

Physicians conceivably may abuse this privilege for any one of four reasons:

a. A patient with limited resources may be certified that the certifying physician may collect a fee for such pre- or post-hospital care as is given at home.
b. Deliberate deception of the Hospital to curry subsequent patronage of the patient and his friends who are not presently clients of the referring physician.
c. Failure to investigate financial status of patient.
d. Deliberate effort to take patient from the private surgical practice of a local surgeon, disliked by the referring physician.

Except through negligence or error in judgment, it is difficult to conceive of a physician so narrow-minded, so shortsighted as to be willing to educate the people of his community to a demand for free attention rather than see a colleague secure a proper fee. If any such be found it would seem proper that they be called to strict account by the county medical society. Any such deceit operates to deny a proper charity case of the facilities provided for him, debars consultants of proper fees, and fosters an unintelligent demand for unwarranted free service that can only react to deprive even the referring physician of a just and proper financial reward in the years to come.

A long, free, and complete discussion of the services of the Wisconsin General Hospital was had at the 1930 Secretaries' Conference in Milwaukee.* In discussing the clinic case, officers of component county medical societies were in agreement that such a classification permitted of an extremely valuable service to physicians and public alike. None suggested that this service be abolished. On the other hand, none condoned any effort by referring physicians which would result in abuse of privileges offered. The question then appears to be one of control.

In the effort to arrive at an impartial estimation of the situation as respects admission of clinic cases, a survey has been completed of 100 consecutive clinic cases covering admissions over a period of approximately nine weeks. Let us now examine this record:

1. *Counties of admission.* Twenty-seven counties are represented. Twelve cases came from physicians in Madison (5 on admission by physicians connected with the Hospital or Medical School, and 7 from physicians not so connected); 16 cases came from physicians in Dane County residing outside of the city of Madison,—a total of 30 cases from Dane County. Other admissions by counties are: Adams 6; Barron 1; Columbia 2; Crawford 1; Dodge 2; Door 1; Grant 2; Green 7; Green Lake 1; Jefferson 3; LaFayette 2; Milwaukee 2; Outagamie 1; Portage 2; Richland 4; Rock 10; Sauk 3; Sheboygan 1; Trempealeau 1; Vilas 2; Washington 1; Walworth 4; Waukesha 1; Waupaca 1; Winnebago 1; Wood 1; and 9 were emergency cases brought to the hospital by passing autoists, etc.

2. *Physicians referring.* Fifty-five physicians referred one case each; 15 physicians referred 2 cases each, and 2 physicians sent in 3 cases each. Nine, as noted previously, were emergency cases.

3. *Financial status.* Keeping in mind that each patient was accompanied by a letter from a physician stating that the patient could pay $5 a day hospital fee, it is of interest to note that 19 of the 100 did not have enough money to pay the first week's care ($35) and were in fact so destitute of funds and property that immediate arrangements had to be made with the respective county judges that they might be admitted as joint state and county charges.

The average income per month of the head of the family in the 100 cases was $64 and the average number of dependents was 2.6. Some 25 had no monthly income at time of admittance; another 24

* See Wisconsin Medical Journal, July 1930, Pages 404 to 414.

had an income of less than $50 a month and but 20 had an income of over $1 per day per dependent.

Now as to savings: Twenty were actually in debt. That means that their outstanding bills exceeded their property and personal holdings on an average of $550 for each of the twenty. Thirty-eight had no actual savings, for their bills outstanding just exactly balanced their property and personal holdings. Six were without any substantial savings and by that is meant they had $300 or less. Thirty-two had savings that averaged $2500 and only four cases stood out as off hand might be considered as able to pay a medical fee. In one such case the assets were frozen in real estate, one was without income due to the illness, the assets of the third were all in the farm he owned and the fourth was a case where assets were tied up in litigation. In each of the four cases the referring physician, by subsequent correspondence, was advised of the financial situation as discovered at the Hospital.

If we grant that physicians made faulty reference in four to six cases in nine weeks by reason of the fact that the individuals should have paid medical or surgical fees, we find on the other hand that 19 cases were sent in to pay their hospital fee where as a matter of fact they were destitute.

The time is not given to discuss the financial situation of each of the cases of the thirty-two that fall into the classification where average assets were $2500. I feel, however, that each was correctly referred when the case is investigated in detail keeping in mind dependents, age, salary earned, amount spent on previous care, and nature of the present illness. A typical case, for instance, is a man of advanced years with two dependents, salary under $75 a month and nature of present illness, cancer.

Because this survey was made at the instance of the Columbia County Medical Society, I do wish to cite here the nine cases reported from that county with the facts discovered by our investigation conducted at the hospital and subsequently through banks and private sources,—an investigation that covered a period of several weeks. These nine cases date back over a period of five years and each is discussed separately.

Case 1. Reported that daughter of county officer "went through the clinic." Records disclose she was admitted by letter from family physician for two days special diagnostic service. It would appear that she should have been referred as a private case.

Case 2. Wife of a "well-to-do farmer" admitted by letter from Dr. B. after Dr. A. refused letter. Investigation discloses farm worth $4,800 mortgaged for $1,125. Owes bank $600 borrowed for physician's bills. Age 52. Cost of this present illness without medical fees was $215. It seems probable that a medical fee in addition would have been a hardship.

Case 3. Reported that son of town chairman was admitted as a clinic case. Was in fact admitted as a state case upon which the County Judge passed.

Case 4. Reported as well-to-do farmer." Investigation discloses that he owns a ten-acre farm with a mortgage and that the poor commissioner said he could probably pay if given time. As a matter of fact his hospital bill was $175, he has paid $50 and a balance of $125 is unpaid three months after leaving the hospital. It seems probable that the reference as a clinic case was correct.

Case 5. Reported as being "well-to-do farmer" and complained that ulcer of leg was treated on clinic case basis. Investigation discloses that he came for x-ray examination and consultation on private fee basis; that no treatment was given and that he was referred back to his family physician who sent him in for such consultation.

Case 6. Reported as wife of farmer who could have paid a private fee. Case was referred in by a physician of the town of residence and was a tonsillectomy for which a $10 hospital bill was paid. No hospital exists in town of residence or in that of referring physician.

Case 7. Complained that this case should have been on a private basis. Accepted as clinic case upon letter from physician in neighboring town, no physician in township of residence. Investigation shows patient to be a young married man of 26, manager of a mercantile company with savings and stock worth $3,000 and $1,000 loaned to a brother. Net worth from $4,000 to $5,000. I agree with complaint that referring physician was in error that patient could not pay. Received operation for orchidectomy, appendectomy, and herniotomy with no hospital in local community. Hospital bill was $80. It would seem the patient should have paid a surgical fee.

Case 8. Reported as a well-to-do farmer. Again letter accompanied from family physician. Investigation discloses that patient has at least $5,000 in ready cash. Referred for diagnosis, stayed four days and sent back to referring physician for treatment. Again it would appear that consulting physician should have had a fee.

Case 9. Patient secured certificate, it is claimed, from neighboring physician after family physician refused. Investigation discloses that patient arrived at Hospital saying that family physician had sent her. Tentatively accepted while Hospital wrote physician saying that patient claimed to have been referred at his instance as a clinic case. Physician did not respond to Hospital advising them of true circumstances and while it may be said that the Hospital should not have received the patient on verbal word, it is also true that physician did not correct the Hospital upon receipt of letter. Possibly this was a result of a misunderstanding but in any event the hospital bill at $5 a day was $145 and subsequent investigation does not assure your Secretary that a medical and surgical fee such as properly would have been charged for care received

in gynecological service would not have been a hardship. I would say that this case is open to question.

Of nine cases reported as examples of abuse found in one county in five years, only one was received without written word from the referring physician. Charges that patient should have paid a private fee appear substantiated in three of the nine cases covering the five-year period but it should be noted that in each such case the fault was that of the referring physician.

Our investigation leads one to appreciate there is no one hard and fast standard upon which one may judge whether a given person is a clinic or private case. One county society, as a basis of determination whether a patient belonged in a clinic or private case classification, used a standard of local credit, viz., could the patient buy a car on credit. Assuming by this the Society had in mind a credit rating of $1,200, there are too many other elements for consideration to permit such a single standard. Thus a young man of 30 earning $100 a month, no dependents, no debts, and a savings of $1200 might well be a private case. On the other hand a man of 60, married, earning $100 a month, future employment uncertain, four dependents and whose life time savings are but $1200 is by no means a private case if faced with a serious illness.

To say whether a patient is rightfully a state, clinic, or private case, one thus must inquire into more than local credit. Age, dependents, whether assets are liquid or frozen, whether assets can be realized upon without great sacrifice, type of illness, health of family, earning ability,—these and other conditions must be considered in arriving at a judgment upon any given case.

SUMMARY

With these facts and this data before you, I feel that each may draw his own conclusions as to percentage of error in admissions. It may be of interest to know that shortly after the hospital was established the percentage of admissions per hundred cases were: state 75%, clinic 15%, and private 10%. For the first six months of the present calendar year our investigation indicates that this percentage table is now changed to read: state 79+%, clinic 12+%, and private 8+%. The decline in numbers of clinic and private cases, and turning upwards of the numbers of state cases, is obvious.

CONCLUSION

Your Secretary has endeavored to paint for you a fair and impartial picture of conditions as they are. He does not say that clinic privileges have not been abused by some physicians in the past. He does not believe that any present abuse is in a percentage scale that warrants other than renewed attention of all physicians to the purposes of the clinic case classification and county society action when intentional abuse is disclosed.

It is therefore suggested, that just as this is not any final report, members continue to advise of instances where privileges seemingly have been abused. To such reports your Secretary pledges his confidence and his every effort. In this suggestion authorities at the Hospital desire to be joined to the end that the Hospital may fulfill those humanitarian principles to which it was dedicated. We should be negligent if we did not acknowledge willingness of the Hospital authorities to be of aid in this research which alone has made the present report possible.

Respectfully submitted,

GEORGE CROWNHART,
Secretary.

Speaker Stovall: The report of the Secretary is most interesting. The report on the cases admitted to the hospital and the financial status of these cases will be most enlightening and will serve as a guide for those people who are formulating opinions as to the type of case that should be referred to this hospital as clinic or state cases.

The reports of these officers will be referred to the Committee on Reports of Officers and reported at our meeting tomorrow afternoon. The report which the Secretary just read is ready for immediate adoption before the House. I would like to know your pleasure.

Dr. Mauermann (Monroe): Mr. Speaker, I move that the report be adopted.

. . . The motion was seconded by Dr. Duer, of Marinette . . .

Speaker Stovall: Is there any discussion? Are you ready for the question?

Dr. Peterman (Milwaukee): I should like to ask the Secretary the source of the funds which have been secured to carry on the free lecture service.

Secretary Crownhart: By that you refer to the extension work, given by the Extension Division, supplying medical library service?

Dr. Peterman: The free lecture service that has been cut off the state budget. Where are the funds secured now?

Secretary Crownhart: We have, at the present time, completed arrangements with President Frank to supply us with a part of the funds. Dr. Bardeen, of the Medical School, is supplying another part. The State Society is turning over certain journals and publications not previously turned over to the medical library service, and the Governor has pledged us $1,000 a year. We hope to carry on pretty nearly at full speed for the next two years. Does that answer the question?

Dr. Peterman: Yes.

. . . The motion was carried . . .

Speaker Stovall: The Committee on Public Policy, Dr. Fiedler.

Dr. Fiedler: Mr. Speaker and Members of the House of Delegates: The Committee has nothing further to report than what you have read in the Journal. The principal work of the committee, during this legislative session, has been perhaps to prevent the passage of certain legislation which we

thought was detrimental to the best interests of the public and the medical profession. On that score, we have been very successful, in that no legislation of that character was passed. While we failed in one or two of the major propositions which we desired to have enacted into law, we secured the enactment of two or three others, as you will read in the printed report.

We come before you now to ask for instruction from the House of Delegates, at this or some subsequent meeting, to ascertain whether you desire us to secure legislation for a physician member on the County Health Committee to supervise the county nurse. Shall the committee introduce such legislation in the next session?

Second, shall we introduce legislation providing for a physician member of the Health Committee in cities.

Third, we should like to inquire whether we shall be instructed to re-introduce a bill which provides for the Medical Grievance Committee. You will remember this was a committee which the House of Delegates authorized us to attempt to secure to cover certain cases in which the practitioner was guilty of misconduct, and which did not exactly justify legal proceedings, but which we thought might be advantageously handled by a Grievance Committee, and which might result in a reprimand and not result in loss of medical status.

Shall the committee re-introduce a bill providing for removing restrictions upon the Governor in making appointments to the State Board of Medical Examiners? Do you wish to authorize us to introduce a bill or support a bill under which the Governor should be free to appoint seven regular practitioners of medicine in the state and one osteopath on this board? As the law now stands, it restricts the activity of the Governor. He must appoint two homeopaths, two eclectics, one osteopath, and three regulars. Shall the committee re-introduce this bill?

Other than that, we have been very successful and the success of the committee is due almost entirely to the activities of your Secretary, as you probably know.

Speaker Stovall: The report we have had from Dr. Fiedler has been very interesting.

With the exception of the report you just heard, presented by the Secretary, these reports will all be considered by the Reference Committees, and you will have them before you for discussion tomorrow, and the advantage of the opinion of your committee for discussion at the same time.

Dr. Fiedler: Dr. Sleyster just told me that I made a mis-statement. There are seven members on the Board of Medical Examiners, three regulars, three homeopaths, two eclectics, and one osteopath. The Governor is limited; he must appoint men from these schools on that Board. The law, as we propose to have it, would give him power to appoint any men who are regular practitioners in the state for six of those offices and one osteopath. It would do away with the distinction between eclectic, homeopath, and regular.

Speaker Stovall: Thank you very much, Dr. Fiedler.

President Harper: I would like to raise the question as to whether that board consists of seven or eight, Dr. Fiedler. I always understood that board to have two eclectics, two homeopaths, one osteopath, and three regulars. I understood you to say seven.

Dr. Fiedler: This is the way I should have said it, eight members altogether.

Speaker Stovall: I will call on Dr. Bardeen, Chairman of the Committee on Medical Education and Hospitals.

Dr. Bardeen: That report has been printed, and I doubt if there is any further discussion.

Speaker Stovall: That report will be referred, then, to the committee as stated.

The Committee on Medical Defense, Dr. Patek. Is he present? The chairmen of these committees are being called on now to emphasize anything in their report to which they want to call special attention. (Dr. Patek not present)

Speaker Stovall: Report of the Editorial Board, Dr. Oscar Lotz, Chairman.

Dr. Lotz: Mr. Chairman and Members of the House of Delegates: During the past year, the routine work of the Journal has been carried on, as usual. The same division of responsibility has continued as in previous years, namely, Dr. Dearholt has taken care of the editorial division; Dr. Joseph Smith and I have taken care of the original article section.

Dr. Podlasky, representing the radiological section, has been very helpful in selecting and editing the papers for the radiological section of the Journal.

The only change of note in the management of the Journal, and I think this is rather an important one, has been the addition of a part time medical assistant to the Editorial Board. You may recall that two years ago, and again at the last annual meeting, your Editorial Board presented to the Council a request for discussion and possible solution of the question of medical editorship of the Journal. After freely discussing the matter at both meetings, the Council decided, and we believe wisely so, that the financial condition of the Society did not, at that time, warrant the additional expense of a full time or part time medical editor.

At the last meeting of the Council, January, 1931, the question again came up for discussion and resulted in a grant of $2500 for the Editorial Board, the money to be used to help make our present Journal a better journal and of greater value to the members of the Society.

After consideration of various possibilities, your Board decided upon the employment of a physician as a medical editor and as an assistant to the Board. This action is in no way to be interpreted to mean that your Editorial Board is going to re-

linquish responsibilities and duties of the Journal and place them on the shoulders of one individual. We would all object to such a policy. But we do feel that while the responsibilities of your publication should remain in the hands of voluntary members, some of the duties may well be transferred to a paid assistant.

It is with pride and considerable pleasure that we announce the appointment of Dr. John Huston of Milwaukee to this position. Dr. Huston is a graduate of the University of Wisconsin and of Harvard Medical School, and we believe will bring to the Journal the interest and enthusiasm so necessary to keep our publication in the front rank of state journals.

Signed,

J. F. SMITH,
H. E. DEARHOLT,
OSCAR LOTZ.

You will perhaps remember, as I have mentioned here, that for several years there has been quite a considerable amount of discussion as to putting someone, some medical man, in charge of the work. For the last fifteen years it has been on the shoulders of the Secretary (not quite that many perhaps, but as long as he has been here) and the Editorial Board. We feel that by having a part time medical man to do some of the reviewing and some of the other work we are going to have a better journal.

I would like to put in a plea for all of you to "come across" with a little more interest for the Journal. I look at some of the Councilors around here who do so much writing. We have begged them for years to do a little writing and it is like pulling teeth. We cannot get it out of them. I would like to get some of the other members to send in a little contribution or an original article for the Journal. After all, it is your journal, not ours, and we want to make it interesting to you. (Applause)

Speaker Stovall: Thank you very much, Dr. Lotz.

Speaker Stovall: The report of the delegate to the A. M. A., Dr. Joseph F. Smith.

Dr. Smith: Mr. Speaker, the report of the delegates has been published in detail in the Journal. There is nothing I care to add except to emphasize one point that might not have attracted your attention.

I call your attention to a resolution presented by Dr. Shoulders, of Tennessee, who recited the fact that the Government had inaugurated the policy of rendering medical and hospital care to World War veterans with non-service connected disabilities, involving the construction, staffing and maintenance of sufficient hospitals to care for all the veterans of the World War, thus bringing the Government into unnecessary competition with civilian hospitals and providing a service which is bound to be of unequal service to the soldiers themselves.

It was pointed out that if the provisions of this bill are carried out it will involve the building, equipping, and staffing of hospitals of capacity which will equal all of the present hospitals of the country. In other words, in order to carry out the provisions of this proposed bill it would require as many hospital beds as we now have in all the civilian hospitals of the United States.

The resolution petitions the Congress to abandon this policy and substitute therefor a Bureau of Disability in the Veterans Bureau and to issue a disability insurance policy which shall provide for (a) the payment of a weekly cash benefit during a period of disability and (b) the payment of hospital benefit sufficient to cover the hospital expenses of a veteran hospitalized for any disability.

It was resolved, that the proper officers of the Association be instructed to approach the proper officers of The American Legion and that each state medical association be requested to form a committee whose duty it shall be to approach the state and local Legion posts, with a view to securing their cooperation in carrying out the proposed plan. This resolution was adopted by the House.

I want to emphasize this resolution, which I think was one of the most important with which the House of Delegates had to deal. Inasmuch as it carries with it a request on the part of the local organization to make contact with the Legion on these points, I think some action should be taken in this matter. (Applause)

Speaker Stovall: Thank you, Dr. Smith. We have two or three more committees with important reports, two particularly.

The first is the report of the Treasurer by Dr. Sleyster.

Dr. Sleyster: The report of the Treasurer for 1930. The fiscal year closes December 31. That, together with the audit of the Treasurer's account, has been published in the Journal. I shall report on the year 1931 up to September 5th.

	General Fund	Medical Defense
Bal. Jan. 1, 1931	250.45	1,950.26
Receipts during year to Sept. 5, 1931	32,355.59	2,692.00
	32,606.04	4,642.26
Disbursements during year to Sept. 5, 1931	18,533.35	2,871.95
	14,072.69	1,770.31

Recapitulation of Funds

General Fund:		
Bank Balance as of Sept. 5, 1931	14,072.69	
Investment securities	20,000.00	34,072.69
Medical Defense Fund:		
Bank Balance Sept. 5, 1931	1,770.31	
Investment securities	7,000.00	8,770.31
		42,843.00

Investment Securities

General Fund:		
Northern States Power Co. 1941–5%	$4,000.00	
Amer. Tel. & Tel. 1936–4%	4,000.00	
Wis. Pub. Serv. Co. 1942–5%	3,000.00	
T. M. E. R. & L. Co. 1961–5%	2,000.00	
Milwaukee Gas Lt. Co. 1967–4½%	2,000.00	
Canadian Nat'l Ry. Co. 1967–5%	2,000.00	
City of Milwaukee 4½%	3,000.00	20,000.00
Medical Defense Fund:		
Commonwealth Edison Co. 1957–4½%	2,000.00	
Bell Telephone of Canada 1955–5%	2,000.00	
Pacif. Tel. & Tel. Co. 1937–5%	1,000.00	
No. Amer. Co. 1961–5%	2,000.00	7,000.00
		27,000.00

Analysis Medical Defense Fund

Bank Bal. Jan. 1, 1931	1,950.26	
Receipts, dues	2,402.00	
Int. on bonds	290.00	4,642.26
Paid Attorneys	931.95	
Bonds purchased	1,940.00	2,871.95
Bank Bal. Medical Defense Fund Sept. 5, 1931		1,770.31

‡ Of the $14,072.69 Bank Balance in the General Fund, the sum of $10,000 is carried in Certificate of Deposit bearing 3% interest.

Speaker Stovall: It is indeed gratifying at this time, when everybody is talking about deficits, to find the State Medical Society does not have a deficit.

The committee on Necrology.

Secretary Crownhart: The following members and non-members have died since the report was printed:

Dr. John W. Cutler, Milwaukee
Dr. S. F. Hutchins, of Trempealeau
Dr. Charles F. King, Hudson (honorary member)
Dr. W. N. Moore, Appleton
Dr. William H. Pugh, Kenosha
Dr. Marion L. Robey, Edgar
Dr. G. M. Steele, Oshkosh

Speaker Stovall: This report is now ready for acceptance.

Dr. Lotz: I move it be accepted.

. . . The motion was seconded by Dr. Harper and carried . . .

Speaker Stovall: One other committee to which I would like to call your attention is the Committee on Health and Public Instruction. The committee report is published in the Journal. I would like to have every delegate read the report of that committee, as it deals particularly with this Committee on Cancer.

This Society, some time ago, was asked by the American Association for the Control of Cancer to cooperate with that organization, whose headquarters are in New York, in carrying out certain procedure which they feel will be of distinct effect in the control of cancer. There are many phases to the problem. There are many definite things that can be done, although we know very little about cancer. But the age of pamphlets is gone. It is no longer profitable to simply educate people to what can be done, and not establish an organization by which those procedures can be carried out.

It has been the policy of your committee for the last year or two years to concentrate its effort on some concrete project which we feel may be fruitful of results. To that end, we have organized for this meeting some special discussion of cancer, and I hope by the time this Society meets next year we will have a report which will be most instructive for the delegates of this house to consider and discuss. So the report is submitted for that purpose and to call to your attention the efforts of your committee, in cooperation with the American Association for the Control of Cancer. I hope that committee may have some more definite things to report to you at another time.

The Committee on the Reports of Officers will consider the reports which have been submitted to them. The Committee on Reports of Standing Committees will consider the report of the Committee on Public Health and Instruction, Medical Education and Hospitals, the Medical Defense and Editorial Board reports. The Committee on the Reports of Officers will consider the report of the Chairman of the Council, the Secretary's and Treasurer's reports, and that of the Delegate to the American Medical Association.

The House now has for its duty the election of the Committee on Nominations. It is customary for the Secretary to read the names of the societies in each district, and as they are read, the delegates from these societies will rise, and, at the conclusion, nominate one from among them to represent the district on this committee.

. . . The Secretary called the roll of districts, which responded with the following nominations:

First District, Dr. H. P. Bowen, of Watertown
Second District, Dr. F. W. Pope, Racine
Third District, Dr. J. F. Mauermann, Monroe
Fourth District, Dr. E. H. Speigelberg, Boscobel
Fifth District, Dr. R. C. Meyer, of Plymouth
Sixth District, Dr. J. W. Lockhart, Oshkosh
Seventh District, Dr. A. E. Winter, Tomah
Eighth District, Dr. A. J. Gates, Tigerton
Ninth District, Dr. S. M. B. Smith, Wausau
Tenth District, Dr. F. E. Butler, Menomonie
Eleventh District, Dr. T. J. O'Leary, Superior
Twelfth District, Dr. H. J. Gramling, Milwaukee . . .

Secretary Crownhart: Now, Mr. Speaker, we are ready to make these nominees the choice of the House.

Speaker Stovall: While the members of these

committees are chosen by the representatives of the various districts, it is the duty of the House to elect them. I will, therefore, receive a motion of acceptance of this committee as the House Committee on Nominations.

Dr. H. T. Barnes (Delafield): I move these nominees be elected.

. . . The motion was seconded by Dr. Thompson, of Milwaukee, and carried . . .

Secretary Crownhart: Mr. Speaker, so that our records may be clear, through a misprint on the Speaker's order of business, the report of the Secretary was adopted this evening. With the consent of the House, may I ask that the adoption of the report be stricken from the record, for it is really to be reported on tomorrow for any discussion you wish. You have the special report in your hands at this time. With your mutual consent, we will ask that portion be stricken from the records.

Speaker Stovall: Is there any objection to striking the approval or acceptance of the Secretary's report from the minutes and referring it to the committee to be discussed tomorrow? If I hear no objection, it will be stricken from the record.

The next order of business is the election of Councilors. The Councilor is elected for each district by the representatives in this House, nominated by the representatives of the counties which compose the district. The Secretary will announce the districts which are to elect a Councilor. We will then declare a recess of five minutes and the delegates from those districts will confer and nominate somebody to succeed or to re-nominate the man who is now Councilor from that district.

Secretary Crownhart: We have, this evening, to elect a Councilor for three years from the third district to succeed Dr. Harper; from the Fourth District, to succeed Dr. Cunningham; from the Fifth District, Dr. A. H. Heidner, of West Bend and from the Sixth District, to succeed Dr. Connell, of Oshkosh.

. . . The Secretary announced the counties composing these districts and the meeting place for nomination caucuses . . .

Secretary Crownhart: Mr. Speaker, in order that there may be no confusion as to the procedure, let the Secretary state it now, before the election of the Councilors. The Constitution provides that the House of Delegates shall elect the Councilors. It has long been the precedent and custom in this House, however, that while nominations are not precluded from the floor, the nominations should preferably come from the delegates within the districts affected. If, in caucus, the district is not able to arrive at a unanimous decision, it should not deprive the delegate who cannot concur in the majority report from making his own nomination. In that event, the House shall choose between the nominees. It does not preclude nominations from the floor. We are now ready to receive the nominations for Councilor from the Third district to succeed Dr. Harper.

Dr. Mauermann: The delegates from the Third District unanimously renominated Dr. Harper as Councilor from the Third District.

Speaker Stovall: Are there any other nominations? Any discussion? Are you ready for acceptance? All in favor of the nomination of Dr. Harper as Councilor from the Third District, will please signify by saying, "Aye"; Dr. Harper is elected.

Secretary Crownhart: We are now ready for nominations for Councilor to succeed Dr. Wilson Cunningham.

Dr. E. H. Spiegelberg (Boscobel): The Fourth District renominates Dr. Wilson Cunningham to succeed himself.

Speaker Stovall: Are there any other nominations? If there are no other nominations, all in favor of this nomination, will please signify by saying, "Aye"; contrary, "No". Dr. Cunningham is elected.

Secretary Crownhart: Mr. Speaker, we are now ready to receive nominations from the Fifth District to suceed Dr. A. H. Heidner, of West Bend.

Dr. Meyer: The delegates of the Fifth District renominate Dr. Heidner.

Speaker Stovall: Are there any further nominations? All in favor of this nomination, please signify by saying, "Aye"; contrary, "No". Dr. Heidner is elected.

Secretary Crownhart: Nominations are in order from the Sixth District to succeed Dr. F. Gregory Connell, of Oshkosh.

Dr. Boyd (Kaukauna): The delegates of the Sixth District agree on the nomination of Dr. S. E. Gavin, of Fond du Lac, as Councilor of the Sixth District.

Speaker Stovall: Any further nominations? If there are no other nominations, all in favor of Dr. Gavin will please signify by saying, "Aye"; contrary, "No". Dr. Gavin is elected.

At this time, I think it is very fitting that we have a word from our President. He may have suggestions to make for the future conduct of this organization.

President Harper: Members of the House of Delegates and Councilors of the State Medical Society of Wisconsin: I wish to say that the courtesy extended me in the little effort I have been able to put forth here and there in the state has been most gratifying, indeed, and has endeared the medical profession to me more than ever. I have endeavored to bring, here and there, little suggestions that I thought would be good for the public and good for the medical profession, in the various changes of government and governmental procedure. It is not unusual for the professional elements of the Society to be incorporated, so to speak, in some of those changes. As we look at other countries, we see that in many instances these changes have been brought about.

I am happy to know that Dr. Fiedler, who will be our President next year will go into this matter in considerable detail, and I believe wisely so.

I think perhaps now, with the general changed conditions, scientific medicne (the best marketable product of any profession in the world) should be brought to the people in that manner and in that method that is directed by members of the medical profession, or the profession as a whole, who are familiar with the application of these scientific procedures.

I have, for many years, been around the Capitol. In fact, I have been in Madison, in the practice of medicine and public health work, since 1894, and I have become very familiar with the legislative procedures, from both within and without. If I do not miss my guess, the people without the medical profession are working harder than ever to become recognized in some phase of the healing art, whatever it may be. The objective is well known, mainly financial return.

This legislature and the preceding legislatures have been importuned to pass measures which are objectionable to the public, or objectionable to scientific medicine. The bunch that get up early in the morning and are waiting to receive legislators have propositions put before them which are not scientifically outlined but which are put there for a selfish purpose. You have a Secretary here who has been able, with the assistance that he has been able to obtain outside, to thwart many of the purely selfish efforts that have been attempted by certain elements. I do not believe, from now on at least, that we should leave all these labors to the Secretary.

I want to emphasize that now is the time to begin to direct scientific medicine in the changes, if any, that may come, and I mean by "directed" that the medical profession direct it along safe channels.

We had measures proposed in the legislature this year, some of which passed and were vetoed, which, if enacted into law, would, indeed, have been extremely objectionable, as far as the welfare of the public is concerned. I need not enumerate them. You will find them outlined, I think, in the August Medical Journal. But those measures are only temporarily dead. They will rise again, and there will be greater forces back of them than ever before. I believe it behooves the local medical societies to take into account the possibilities of the future, and begin now to direct their forces along sane lines to meet the conditions as they arise.

I do not think we should take the attitude, "Well, if the public wants it, let them have it." That has been the statement which I have heard many times in the past, and I think it is out-dated. You are interested in the public welfare, more than any other group of people, and I believe it is not only your privilege but your duty to take a part, and an active part, in guiding the public along those channels which are for their best interest, first, last, and always.

I hope, you will contact those people, through your local societies, particularly those people who are representing you in the great legislature of this state, and hold such meetings as will acquaint them with your purposes, your objectives. So, when they come down here, they will have at least the rudiments of what may be expected when it comes to legislative procedure.

Do not think that legislation is easy. I have had men come to me during this last session and say, "Here, what am I going to do. I have not had a letter from a medical man in my district, and yet I have letters galore from certain cults and interests." And they showed me great piles. They would say, "I would like to be backed up a little by the medical profession. I am not going to vote with these others, but it helps, when you are making your argument, and during the intermission of the legislature, in your contact with other men, to have letters from the regular medical men in your territory advocating this and opposing that." I believe that is a duty which we should feel is ours.

I have had opportunity, during the last year, of coming in contact with your office, of which Mr. Crownhart is Secretary. When you see George, he is always pretty cheerful and lively. Sometimes I have slipped over there to see whether George was busy, and I want to say he was busy. During the last session of the legislature, night and day, for six months, he had to watch many things. It is extremely difficult to keep in touch with everything. I am sure that he has a mighty busy office. The assistants he has are not beyond what he needs. Therefore, if there is any doubt about any assistants that come into that office, I would like to say, in connection with the many frequent visits I have made there, he has had work piled up and waiting for him, and it has been good work. There is an immense amount of work to be done there.

There are many little things that come to the administrative office, about which you do not know. There are so many little details here and there that require time, judgment, and careful consideration, which are taken care of, and yet they do not come to your knowledge. I think that is true in every administrative office. I think the medical profession owe to the local organizations the assistance which they can give from the central office, in carrying out the medical program that the great State Medical Society of Wisconsin desires to have carried out.

I appreciate, as I said before, all the courtesies which have been extended to me. Nothing has been more pleasing than the results of the letter sent to you from the office seeking your cooperation in this infantile paralysis situation, in picking up convalescents, so that we could get blood serum. After that letter went out, telephone calls came in from all over the state at the expense of the local men, and the cooperation was greater in that field this year than at any time we have had cooperation in my twenty-eight years of public health work in the state. So if you continue, along other lines, that cooperation and assistance which has aroused you right up to the highest peak, then the medical profession is going on and on in Wisconsin and will exceed that of any other state. (Applause)

Speaker Stovall: Dr. Harper, I think the honor that was conferred upon you by this Society at its annual dinner last year, and your election to the presidency of this office, expresses the confidence that the Society has in your judgment in matters affecting the profession and the public. I am sure that we appreciate your remarks and advice that the medical men should pay more attention, for the sake of the public, to medical legislation.

I thank you very much.

Dr. Mauermann: I wish to say just a few words in connection with the statement Dr. Harper made in connection with getting in close touch with your assemblymen and senators during the coming year. I think one of the best investments any county society can make is to invite them to their county meetings. When we invite them, they will have more of a personal interest in our work and first hand information of our efforts.

Speaker Stovall: The incoming President, in order to carry out the business of the Society and the business of the office next year, has to appoint certain committee members. Those committee appointments must be confirmed by this House. I, therefore, call upon Dr. Fiedler to make an announcement of his committees for confirmation.

President-Elect Fiedler: I wish to submit the following names for the respective committee vacancies:

Committee on Public Policy
Dr. Reginald Jackson, Madison.
Scientific Work, Program Committee
Dr. Theodore L. Squier, Milwaukee.
Medical Education and Hospitals
Dr. Joseph Lambert, Antigo.
Editorial Board
Dr. H. P. Greeley, Madison.
Medical Economics
Dr. Victor F. Marshall, Appleton.
Medical Defense
Dr. Arthur Sullivan, Madison.
Advisory Committee on Medical Extension
Dr. Karl H. Doege, Marshfield.
Dr. A. J Wiesender, Berlin.
(to succeed the President who resigns.)
Health and Public Instruction
Dr. H. M. Stang, Eau Claire.

Speaker Stovall: You have heard the nominations of your incoming President; these names can be acted upon individually or collectively. If I hear no objection, the nominees will be acted upon collectively. I would like to know your desire in the matter. All in favor of acting upon those names collectively, say, "Aye"; opposed, "No". The "Ayes" have it and the nominations of the incoming President are before you to be acted upon collectively.

Dr. W. F. Lorenz (Madison): I move the nominations be accepted.

. . . The motion was seconded by Dr. Mauermann, of Monroe, and carried . . .

Speaker Stovall: The next important function of this House is acting upon resolutions and the receiving of resolutions on important matters affecting the Society. Resolutions will now be received and will be referred to the Committee on Resolutions. The person who offers a resolution will please read the resolution and refrain from discussion except to clarify what he means, as the resolution will be up for discussion when it is reported by the Committe on Resolutions tomorrow.

Dr. D. E. W. Wenstrand (Milwaukee): Mr. Speaker, the delegates of the Milwaukee Medical Society have been instructed by the County Medical Society to propose this resolution:

Whereas, the American Medical Association has not, as yet, selected the place of its annual meeting for the year 1933; and

"Whereas, the Medical Society of Milwaukee County has already invited the American Medical Association to hold its 1933 meeting in the city of Milwaukee; and

"Whereas, the State Medical Society of Wisconsin is anxious that the American Medical Association hold its convention in the state of Wisconsin; now therefore be it

"*Resolved*, that the State Medical Society of Wisconsin concur and join with the Medical Society of Milwaukee County in inviting the American Medical Association to hold its annual meeting for the year 1933 in Milwaukee; and be it further

"*Resolved*, that in the event the American Medical Association should accept the invitation of the Medical Society of Milwaukee County to hold its annual meeting in Milwaukee in 1933, that the State Medical Society of Wisconsin would not hold its annual meeting for the year 1933; and be it further

"*Resolved*, that the State Medical Society of Wisconsin turn over to the Committee on Local Arrangements of the Medical Society of Milwaukee County the funds which would be available for the 1933 meeting of the State Medical Society of Wisconsin, for their use in connection with the American Medical Association Convention; and be it further

"*Resolved*, that the Secretary of the State Medical Society be and hereby is instructed to transmit a copy of this resolution to the Medical Society of Milwaukee County and the proper officers of the American Medical Association."

Speaker Stovall: Are there any other resolutions?

Dr. J. O. Dieterle (Milwaukee): This is also a resolution sponsored by the delegates of Milwaukee County:

"Whereas, the Congress has undertaken to fix the doses of wine and whiskey and brandy by legislative fiat, thus taking over the functions of pharmacologist and physician; and

"Whereas, the Volstead Act compels physicians to betray the confidences of their patients by keeping a record of their diseases and ailments for inspection by Federal prohibition agents, thus violating the traditions of the medical profession,

medical ethics, and the laws of a number of states; and

"Whereas, relief from these conditions has been sought in the courts and has been denied by the United States Supreme Court; and

"Whereas, the Wickersham Commission has unanimously made the recommendation:

"(1) Removal of the causes of irritation and resentment on the part of the medical profession by;

"(a) Doing away with the statutory fixing of the amount which may be prescribed and the number of prescriptions;

"(b) Abolition of the requirement of specifying the ailment for which liquor is prescribed upon a blank to go into the public files;

"(c) Leaving as much as possible to regulations rather than fixing details by statute; now therefore be it

"*Resolved*, that the State Medical Society of Wisconsin hereby formally expresses its disapproval of those portions of the Volstead Act which invade the right of the state of Wisconsin to regulate the practice of medicine within its own borders and which deprive the physician of his right to the free exercise of his judgment in the practice of his profession; and be it

"*Resolved*, that the State Medical Society of Wisconsin urge each of its members to demand of his Senators and Congressmen the repeal of said portions of the Volstead Act; and be it further

"*Resolved*, that the Secretary of the State Medical Society of Wisconsin be, and hereby is, instructed to transmit a copy of these resolutions to the senators from Wisconsin and to each representative in Congress of the state of Wisconsin."

President-Elect Fiedler: Mr. Chairman and Members of the House: I have a resolution which I would like to present to the Society.

"Whereas, there exists in America today a widespread dissatisfaction with the distribution of medical service; and

"Whereas, the Committee on the Cost of Medical Care has about completed its survey, making available considerable data on the subject; and

"Whereas, social medicine, which has been in more or less successful operation in Europe, is now being advocated as a solution of this problem in America; now therefore be it

"*Resolved*, by the House of Delegates of the State Medical Society of Wisconsin that the President, with the advice of the Council, and subject to its approval, appoint a committee of three to study this whole subject and report back to the 1932 House of Delegates its findings and recommendations, and, further, that the Council authorize the expenditure of the necessary funds to make such a survey and report possible."

Speaker Stovall: These resolutions will be referred to the Committee on Resolutions.

Is there any other new business to come before the House?

Dr. S. D. Beebe (Sparta): Before I go, I want to ask a question. This has been a wonderful gathering. I want to assure you right away that I have no ax to grind, no story to tell or any monkey wrench to throw into the machinery of this well oiled meeting. But I do want to ask a question. Just to make a little background for what I am going to say, I want to recite this fact.

I was, for a number of years, a delegate to this House of Delegates, and then, for some reason or other, they made me Councilor. Now I am asking a question. When I was a delegate, I resented the fact that Councilors were allowed to vote in the House of Delegates. I cannot understand why we, as Councilors, should have the right to vote in the House of Delegates. I do not object to it. I am going right along. But I wish some Councilor would explain to me how it originates and why it is so, this House of Delegates being the representative body of the State Medical Society.

I am not asking that to make it difficult, but perhaps some Councilor, who has been on the Council longer than I, can explain.

Speaker Stovall: Is there any one present who can answer Dr. Beebe's question.

Dr. Cunningham (Platteville): I think the by-laws, as adopted by the State Medical Society were those as outlined by the American Medical Association when they recommended the new organization be formed. I think we have followed that precedent since.

Dr. Sleyster: I think Dr. Cunningham's answer is correct. The model Constitution and By-Laws of the State Society, as worked out by the American Medical Association, contain that recommendation, allowing Councilors to vote. Personally, I am opposed to it. The American Medical Association, itself, is not so organized, in connection with the Board of Trustees.

The Councilors of the State Society are now members ex officio of the House of Delegates of the State Medical Society with the right to vote. Considering strict representation, the Council, which is an executive committee, should not have the power to vote.

Personally, I would be willing to subscribe to an amendment to the Constitution and By-Laws that would make the members of the Council ex officio members of the House of Delegates, but without the right to vote.

Secretary Crownhart: For Dr. Beebe's further information, in the event the Doctor wishes to offer such an amendment, it would have to lay on the table for one year. It would be appropriate now to give notice that he wishes to present it for action next year.

Dr. Beebe: I have no notion of introducing such an amendment. When you remember that twelve Councilors and all the state officers of the Society are allowed to vote in the House of Delegates, besides their own members, you can easily imagine there may arise a situation which might be embarrassing, where you may wish to decide an import-

ant question, and where the Council and the officers of your State Medical Society could hold the power.

It is a question, in my mind, whether the House of Delegates wants to delegate that power to the Council. We will take, for instance, the election of the Council. Supposing one of those delegations come in tonight with four men in favor of one candidate from their district and one man in favor of another. They would make that recommendation to the House. The Council, easily, has the balance of power in that event. In either case, the district could not get the man it wanted. I just cite that as an instance. I am not looking forward to next year when the boys may "bump me off". I will try to figure some way they cannot do it. It may, however, create an embarrassing situation. If we are trying to have a representative form of government, I cannot understand why this situation should be continued throughout the year.

Dr. Arthur W. Rogers (Oconomowoc): As Chairman of the Council, I think I might speak for them. We are not particularly solicitous, I am certain, of the privilege of voting in the House of Delegates. The fact is we did not know until this afternoon that we could. If Dr. Beebe has any objection to it, instead of talking about it, why not produce the remedy. We would be glad to follow such proposal.

Dr. Beebe: I would be glad to introduce that resolution. The fact of the matter is we have been voting at every meeting for six years. The Councilors sat on the front seat and did most of the discussing and a great deal of voting.

Secretary Crownhart: We will assume, Dr. Beebe, that your notice is that at the next session such an amendment will be worded for House action. Is that correct?

Dr. Beebe: Yes.

Secretary Crownhart: I would like to call to the attention of the House at this time that due to a pure oversight, at the last annual meeting, there was an amendment to the Constitution on the table. It was taken up, and then we got into discussion of another subject, and from there to another one. While we went back to B we didn't go back to A. I call your attention to the fact that probably tomorrow afternoon we should vote on this amendment, which provides as follows:

"Members in good standing who shall make outright gifts to the Endowment Fund of this Society, in the amount of $1,000 or more, shall have bestowed upon them the gift of life membership in this Society. Such membership shall carry with it all the prerequisites of active membership, without the requirements of annual dues, and shall continue in force during the life of the member, provided that the member continues in good standing in his local County Medical Society."

If there is no objection, we will take that up at the session tomorrow afternoon.

I would like to ask whether Mr. E. E. Parkinson, Secretary of the Wisconsin State Dental Society is in the room? (not present)

The next meeting is to be determined by the House, but it has been the custom of the Secretary to select such time as may be advantageous. This year we cannot have a session which does not conflict with one of the scientific sessions. The next meeting, subject to your approval, will be held tomorrow afternoon at one-thirty, when these committee reports will be before you.

. . . The Secretary made announcements regarding committee meetings . . .

Secretary Crownhart: The Committee on Nominations has as its Chairman Dr. Gates of Shawano County. The report of the Committee on Nominations is to be given, sealed, to the Secretary, and will be presented at the afternoon session on Thursday afternoon.

Dr. F. G. Johnson, of Iron River, Wisconsin, wishes to give notice that his councilor district may wish to meet and separate and create a thirteenth district. He wishes that it be announced and that it lay on the table to be acted upon a year hence.

That concludes the business on the Secretary's desk, Mr. Speaker.

Speaker Stovall: If there be no other business, this House of Delegates will adjourn to meet tomorrow afternoon at one-thirty.

. . . Adjournment at nine-thirty p. m. . . .

(Adjournment)

WEDNESDAY AFTERNOON SESSION

September 9, 1931

The meeting was called to order at one-thirty p. m. by Dr. H. M. Stang, the Vice-Speaker.

You will please come to order, gentlemen. The first order of business is the report of the Committee on Credentials.

Dr. C. W. Henney: There are present thirty-nine delegates, eleven alternates, and fiften officers, who have registered at the desk.

I move this list, so certified, constitutes the roll of this House of Delegates, for this meeting.

. . . The motion was seconded by Dr. McMahon . . .

Chairman Stang: Moved and seconded that the report of the Credentials Committee be accepted.

. . . The motion was carried . . .

Chairman Stang: The next are reports of Reference Committees. We will have first the report of the Committee on the Reports of Officers, Dr. F. A. Thompson, of Milwaukee.

Dr. Thompson: Your Committee on Reports of Officers respectfully submits, for your consideration, the following report:

Secretary's Report: The recommendation contained in the Secretary's report, sponsored originally by R.W. Blumenthal, who urged provision for an adequate state inspection and licensing of all hospitals and institutions that house the sick, is endorsed by your committee.

Under the present connection with the Wisconsin

Hospital Association, it is suggested that the Secretary be authorized to ascertain whether or not a licensing measure may be drafted for presentation to the 1933 legislature that will meet with joint approval.

Legislation pertaining to matters of public health proposed by lay organizations such as the Federation of Labor, American Legion, Federation of Women's Clubs, Wisconsin Conference of Social Work, Association for the Care of the Disabled, etc.:—It is recommended that such contacts be made with these different organizations, and the officers of the State Medical Society and members of the Council as will place the service of the Society at the command of any organization interested in public health legislation, to the end that they (the lay organizations) may have the benefits accruing from the advice of specialists in this field.

In the report of the delegates to the American Medical Association, they report that a resolution introduced by Dr. H. H. Shoulders, of Tennessee, reciting the fact that the government had inaugurated the policy of rendering medical and hospital care to World War Veterans with non-service connected disabilities involving the construction, staffing and maintenance of sufficient hospitals to care for all the veterans of the World War, thus bringing the government into unnecessary competition with civilian hospitals and providing a service which is bound to be of unequal service to the soldiers themselves.

The resolution petitions the Congress to abandon this policy and substitute therefor a Bureau of Disability in the Veterans Bureau and to issue a disability insurance policy which shall provide for (a) the payment of a weekly cash benefit during a period of disability, and (b) the payment of hospital benefit sufficient to cover the hospital expenses of a veteran hospitalized for any disability.

It was resolved that the proper officers of the Association be instructed to approach the officers of The American Legion and that each state medical association be required to form a committee whose duty it shall be to approach the state and local Legion posts with a view to securing their cooperation in carrying out the proposed plan. This resolution was adopted by the House.

Your Committee, in concurrence with the American Medical Association, recommends the appointment of a committee from the State Medical Society of Wisconsin, consisting of a sufficient number who can approach the state and local Legion posts with a view to securing their cooperation in the carrying out of this plan.

Your Committee wishes to comment very favorably upon the careful and well presented reports of your delegates to the American Medical Association, and suggests that all the members of this Society will find them interesting and instructive.

The only comment that your Committee makes upon the Treasurer's report is that in view of the unfavorably financial condition the Society reflects a generally well maintained interest in our State Society.

Respectfully submitted,
F. A. THOMPSON,
A. J. WIESENDER,
E. H. SPEIGELBERG.

The suggestion contained in this report, that the activities of the medical profession be brought to the attention of the public in a sane and sensible way is to be commended. It is the opinion of the committee that more work can be done along that line,—that the medical profession alone can give reliable information at all times; that it should be a prime factor in every community in the promotion of sensible health measures; that it should pass opinion on doubtful fads and freak measures of health, and that it should take its place as proper advisor in all public health measures.

In regard to the special report on the State of Wisconsin General Hospital, the committee has no further comments to make. From this report, it would appear that there is no undue abuse of the privileges of the Hospital at the present time. Attention of the physicians to the clinic case classification should be stressed and the County Society should take action when intentional abuse of the privileges of the hospitals is disclosed, as suggested by the Secretary.

Respectfully submitted,
F. A. THOMPSON,
A. J. WIESENDER,
E. H. SPEIGELBERG.

Chairman Stang: Again we wish to bring before the members of this assembly that this is your meeting and that you should speak freely before the House. If you have anything to bring up, do so, and have it discussed openly at the present time. If there are no objections, we will ask for a motion accepting this report as a whole.

Dr. Wenstrand (Milwaukee): I make such a motion.

. . . The motion was seconded by Dr. Duer, of Marinette, and carried . . .

Chairman Stang: Report of the Committee on Reports of Standing Committees, by Dr. C. D. Boyd, of Kaukauna.

Dr. Boyd: Preliminary to the report of the Committee on the Reports of Standing Committees, I think the members would want me to say they are impressed with the thoroughness and the sacrifices they have made in the exercise of their duties as committeemen.

"*Committee on Medical Education and Hospitals.* The report of the Committee on Medical Education and Hospitals indicates a progressive trend of thought and that this Committee is alert to the needs of the times. We recommend this report be approved."

I move the adoption of this portion of the report.

. . . The motion was seconded by Dr. Mauermann and carried . . .

Dr. Boyd: "*Committee on Public Policy.* Your Committee on the Reports of Standing Committees begs to report as follows: That the report of the Committee on Public Policy be approved and that said committee be authorized to prepare and introduce bills in the next legislature to conform with Sections 1 and 2 of their report. We further recommend that the bills referred to as one and two in the second section of their report be re-introduced in the next session of the legislature."

I take it for granted, without going into these reports at all, as they were published in the Journal, that most of you are familiar with them.

I move the adoption of this portion of the report.

. . . The motion was seconded by Dr. Peterson, of Independence . . .

Secretary Crownhart: So it will be perfectly clear what those bill are, I would like to say that the Reference Committee recommends that the Committee on Public Policy introduce in the next session of the Legislature these two bills; providing for a physician member on the County Health Committee who supervises the work of the county nurse, and providing for a physician member of health committees in cities.

This Committee recommends that the Committee on Public Policy re-introduce, at the request of the Society, these two bills which were killed this year. A bill providing for a Medical Grievance Committee. A bill providing for removing certain restrictions upon the Governor in making appointments to the State Board of Medical Examiners.

Dr. Heidner: Why was not the Grievance Committee bill passed and also what objection was raised to the member on the County Health Committee?

Secretary Crownhart: In connection with the member on the County Health Committee, that bill was introduced but was combined with other measures affecting the duties of the County Health Committee, as suggested by the State Board of Health. Part of it was a State Board of Health proposition, and part was ours. It was killed because of material incorporated there by the State Board of Health, which, unobjectionable to us, did not meet with legislative approval. Next time we will introduce it as a single item coming from this Society.

As to the Grievance Committee, I cannot tell you why it was killed, unless it was because it was new and not sufficient thought was given to it.

Dr. Lorenz: What is the suggested change in regard to restrictions upon the Governor, in connection with appointments on the State Board of Examiners.

Secretary Crownhart: Under the present law, Dr. Lorenz, the Board is composed of two eclectics, two homeopaths, three designated in the law as allopaths, and one osteopath. The proposed change introduced at this session, but defeated, introduced at the request of this House, was that the Governor appoint seven practicing physicians and surgeons and one osteopath. They might be eclectics or homeopaths or regulars, but no proportion was stated.

. . . The House considered the proposal in Executive Session . . .

Chairman Stang: We are glad to have this discussion. Are you ready for the question?

Those in favor of the original resolution say, "Aye"; opposed, "No". It is carried.

Dr. Boyd: "Committee on Medical Extension. Your Committee recognizes the amount and importance of the work performed by Dean Snell in the Medical Extension Department, and recommends that report be adopted and an expression of appreciation be extended to Dean Snell and the Medical School through Dr. C. R. Bardeen for their efforts in this matter."

I move the adoption of this report.

. . . The motion was seconded by Dr. Redelings, of Marinette, and carried . . .

Dr. Boyd: "Editorial Board. We recommend the adoption of the report of the Editorial Board."

I move the adoption of this portion of the report.

. . . The motion was seconded by Dr. Webb, of Beaver Dam, and carried . . .

Dr. Boyd: "*Committee on Medical Defense.* The report of the Committee on Medical Defense is to be commended and we recommend the adoption of that portion of the report."

I move the adoption of that portion of the report.

. . . The motion was seconded by Dr. Henney and carried . . .

Dr. Boyd: "*Committee on Health and Public Instruction.* The report of the Committee on Health and Public Instruction shows a keen interest in that subject and we recommend the adoption of that report."

I move the adoption of this portion of the report.

. . . The motion was seconded by Dr. Wright, of Antigo, and carried . . .

Dr. Boyd: I move the adoption of this report as a whole, for the Committee on the Reports of Standing Committees.

. . . The motion was seconded by Dr. S. M. B. Smith, of Wausau, and carried . . .

. . . Speaker Stovall in the chair . . .

Speaker Stovall: The next order of business is the report of the Reference Committee on Resolutions by Dr. Gunnar Gunderson, of La Crosse.

Dr. Gundersen: The Committee on Resolutions has a resolution of its own, as well as three submitted by various members of the Society.

The first one: The Committee recommends that the amount of dues for 1932 remain at fifteen dollars per year, as at present.

I move the adoption of this recommendation.

. . . The motion was seconded by Dr. Prentice, of Ashland, and carried . . .

Dr. Gundersen: In regard to the resolution introduced by Dr. Otho Fiedler, regarding the appointment of the Committee of Three to work with the Committee on the Cost of Medical Care; and the resolution is recommended for adoption.

Secretary Crownhart: Dr. Fiedler's resolution is:

"Whereas, there exists in America today a widespread dissatisfaction with the distribution of medical service; and

"Whereas, the Committee on the Cost of Medical Care has about completed its survey, making available considerable data on the subject; and

"Whereas, social medicine, which has been in more or less successful operation in Europe, is now being advocated as a solution of this problem in America; now therefore be it

"*Resolved*, by the House of Delegates for the Wisconsin Medical Society that the President, with the advice of the Council, and subject to its approval, appoint a committee of three to study this whole subject and report back to the 1932 House of Delegates its findings and recommendations, and, further, that the Council authorize the expenditure of the necessary funds to make such a survey and report possible."

Dr. Gundersen: I move the adoption of the resolution.

. . . The motion was seconded by Dr. Remer, of Chaseburg, and carried . . .

Dr. Gundersen: A resolution introduced by Dr. John O. Dieterle in regard to the matter of liquor prescriptions. The resolution is recommended for tabling.

Secretary Crownhart: The resolution is as follows:

"Whereas, the Congress has undertaken to fix the doses of wine and whiskey and brandy by legislative fiat, thus taking over the functions of pharmacologist and physician; and

"Whereas, the Volstead Act compels physicians to betray the confidences of their patients by keeping a record of their diseases and ailments for inspection by Federal prohibition agents, thus violating the traditions of the medical profession, medical ethics, and the laws of a number of states; and

"Whereas, relief from these conditions has been sought in the courts and has been denied by the United States Supreme Court; and

"Whereas, the Wickersham Commission has unanimously made the recommendation:

"(1) Removal of the causes of irritation and resentment on the part of the medical profession by:

"(a) Doing away with the statutory fixing of the amount which may be prescribed and the number of prescriptions.

"(b) Abolition of the requirement of specifying the ailment for which liquor is prescribed upon a blank to go into the public files;

"(c) Leaving as much as possible to regulations rather than fixing details by statute; now therefore be it

"*Resolved*, that the State Medical Society of Wisconsin hereby formally expresses its disapproval of those portions of the Volstead Act which invade the right of the state of Wisconsin to regulate the practice of medicine within its own borders and which deprive the physician of his right to the free exercise of his judgment in the practice of his profession; and be it

"*Resolved*, that the State Medical Society of Wisconsin urge each of its members to demand of his Senators and Congressmen the repeal of said portions of the Volstead Act; and be it further

"*Resolved*, that the Secretary of the State Medical Society of Wisconsin be, and hereby is, instructed to transmit a copy of these resolutions to the senators from Wisconsin and to each representative in Congress of the state of Wisconsin."

Dr. Gundersen: I move that the resolution be tabled.

. . . The motion was seconded by Dr. Redelings . . .

Dr. McMahon (Glenwood City): In tabling, does that mean that it will be brought up again at the next meeting?

Secretary Crownhart: A resolution laid on the table may be taken from the table at any time by a majority vote of the House of Delegates.

Speaker Stovall: Are you ready for the question? All in favor of this motion say, "Aye"; opposed, "No". The motion is carried. The resolution is tabled.

Dr. Gundersen: The next is the resolution inviting the American Medical Association to meet in Milwaukee in 1933.

Secretary Crownhart: The resolution is:

"Whereas, the American Medical Association has not as yet selected the place of its annual meeting for the year 1933; and

"Whereas, the Medical Society of Milwaukee County has already invited the American Medical Association to hold its 1933 meeting in the city of Milwaukee; and

"Whereas, the State Medical Society of Wisconsin is anxious that the American Medical Association hold its convention in the state of Wisconsin, now therefore be it

"*Resolved*, that the State Medical Society of Wisconsin concur and join with the Medical Society of Milwaukee County in inviting the American Medical Association to hold its annual meeting for the year 1933 in Milwaukee; and be it further

"*Resolved*, that in the event the American Medical Association should accept the invitation of the Medical Society of Milwaukee County to hold its annual meeting in Milwaukee in 1933, that the State Medical Society of Wisconsin would not hold its annual meeting for the year 1933; and be it further

"*Resolved*, that the State Medical Society of Wisconsin turn over to the Committee on Local Arrangements of the Medical Society of Milwaukee County the funds which would be available for the 1933 meeting of the State Medical Society of Wisconsin for their use in connection with the American Medical Association Convention; and be it further

"*Resolved*, that the Secretary of the State Medical Society be and hereby is instructed to transmit

a copy of this resolution to the Medical Society of Milwaukee County and the proper officers of the American Medical Association."

Dr. Gundersen: In regard to that resolution, introduced by the Milwaukee County Medical Society, relating to the invitation to the American Medical Association to meet in Milwaukee in 1933 and an appropriation of funds for that meeting, the committee concurs in Paragraph IV, that the invitation be extended, to hold the meeting in Milwaukee, and recommends that the State Society hold its own meeting, as in the past.

The committee felt there were certain matters of routine business that should be conducted annually, and that we should not forego holding a meeting of our own, due to the fact that the American Medical Association happens to hold its meeting in Milwaukee. We felt we should have a meeting of the State Society regardless of that.

In connection with the question of contribution of funds from the treasury to help defray the expenses of the Milwaukee Committee, we recommend that this be referred to the Council for further consideration. It is the consensus of opinion of the committee that the State Society give the Milwaukee County Committee financial support in putting on the 1933 meeting of the American Medical Association in case it is to be held in Milwaukee, but our thought is that the Council will be in best position to determine the amount.

I move the adoption of the resolution, as amended by the Committee.

Secretary Crownhart: We understand your recommendation is that as far as finances are concerned, you are in accord with that, but that it be referred to the Council. As far as our own meeting is concerned, do you suggest we hold our scientific meeting or merely the meeting of the House of Delegates?

Dr. Gundersen: We leave that to the Council. If there is a scientific meeting in Milwaukee, in connection with the American Medical Association, we felt it might be advisable to hold only a meeting of the House of Delegates, to conduct the routine business.

Speaker Stovall: You have the proposition before you, of extending the invitation to the American Medical Association to meet in Milwaukee in conjunction with the Milwaukee Medical Society and the State Medical Society, with two modifications, which will be two amendments.

First, that the State Medical Society hold its own meeting, which is an amendment of the resolution.

Second, if in the discretion and the opinion of the Council the State Medical Society should furnish funds for that meeting, it should be done. Is it clear? Are you ready to vote on these amendments to the original resolution?

Dr. Rogers: Do I understand that the Council has the final say?

Speaker Stovall: That is what I understand, that the Council has the final say in the distribution of funds.

Dr. Prentice: As I understand, the Council is to decide whether we are to have a regular state meeting or to pass over the scientific program and have only a business session, in connection with the national meeting.

Speaker Stovall: Dr. Gundersen will correct me if I am not correct, but, as I understand, we will proceed with our regular state meeting.

Dr. Prentice: Including the scientific program?

Speaker Stovall: That is to be decided here and now. There are two things to decide with these modifications. The committee recommends that instead of dispensing with our regular state meeting we proceed as usual with our state medical meeting.

Second, the distribution of funds for this meeting of the American Medical Association in Milwaukee be left to the discretion of the Council. Do you understand the motion.

Dr. Higgins (Milwaukee): Does the recommendation of the committee say the State Society shall have its own meeting as usual, or as may be modified by the Council. As I understood the discussion, you thought you might just have a meeting of the delegates. You could have a meeting of the State Society called at the same time as the American Medical Association meeting, without the scientific program, which would give the state the medical meeting with the House of Delegates. Do I understand the Council is empowered to designate the time of the meeting and the plans?

Dr. Gundersen: The committee felt the State Society should go ahead with its meeting just the same as it has in the past, because it had its routine business to carry on and it was important not to disrupt the routine of business of the State Society and that the meeting of the American Medical Association in Milwaukee should not interfere with the activities of the State Society whatsoever.

Dr. Powers: (Milwaukee): What about the scientific program?

Dr. Prentice: Does that come at the same time?

Dr. Gundersen: No, because the American Medical Association is held in June and our meeting is held in September. There is three months' interim.

Dr. Rogers: It has been said the Council should vote the money usually used for the State Medical Society meeting. Then they go on to say, "Let's have the State Medical Society meeting." Where is there going to be enough funds for the Council to hand over?

Speaker Stovall: Dr. Rogers says if we contribute to the entertainment and holding of the meeting of the American Medical Association in Milwaukee there will be no funds for the regular state medical meeting. The committee has said, however, that we should proceed with our usual State Medical Society meeting in September, as if there were no meeting in Milwaukee of the American Medical Association in June. If in the discretion of the Council, the State Medical Society can afford to contribute to the support of the meeting of the American Medical Associaion in June that the Council do so, but it is left to the Council to de-

termine whether the Society is financially able to put on their own society meeting and, at the same time, to contribute funds to the American Medical Association.

Dr. Rogers: It is a pretty good guess for the Council to decide on the funds.

Dr. Gundersen: It is passing the buck.

Dr. McMahon: When the American Medical Association met in Minneapolis in 1928, I believe the Minnesota State Medical Association held a meeting at the same time. I am sure they did not have any scientific program of their own, but probably met only to conduct the business of the Society. There is no reason why this House of Delegates could not meet at the same time the American Medicad Association holds its meeting in Milwaukee and conduct the business, dispensing with the scientific program, especially since it seems there would not be any funds to hold both a state meeting and contribute to the American Medical Association meeting.

Dr. Rogers: I think everybody has in mind that when we hold a meeting it is a meeting of the House of Delegates. There should be something to the effect of eliminating the scientific program. I do not see how we could meet the expenses of our own Society in the face of the American Medical Association meeting in Milwaukee.

Speaker Stovall: Suppose we have a little discussion on the part of this House of Delegates. That is one of the recommendations of this committee, that this society have its regular meeting.

Dr. Gramling (Milwaukee): I offer an amendment, that we do without a scientific program, just have a meeting of the House of Delegates.

. . . The motion was seconded by Dr. Dull, of Richland Center . . .

Speaker Stovall: Your committee has made one recommendation. You will have to dispose of that first.

Dr. Fiedler: May I ask Dr. Wenstrand, who introduced this resolution, whether it was the idea there should be no scientific meeting of the State Medical Society or whether it be a meeting of the House of Delegates.

Dr. Wenstrand: I am not quite clear as to that. I did not draw up the resolution, but I amagine it had to do very largely with the scientific meeting and not the House of Delegates. The House of Delegates, naturally, has to meet.

Dr. Fiedler: Would it be possible, Dr. Wenstrand, to just say "No scientific meeting"?

Dr. Wenstrand: By simply eliminating the scientific meeting.

Speaker Stovall: Dr. Gramling, will you restate your amendment?

Dr. Gramling: I offer an amendment to the resolution, that the House of Delegates of the State Medical Society meet at the same time as the American Medical Association meets in Milwaukee, and that we have no scientific meeting of the State Society, no meeting in the fall.

Speaker Stovall: The amendment is that the House of Delegates meet in Milwaukee at the same time as the meeting of the American Medical Association, if it meets in Milwaukee, and that there be no regular scientific program of the State Medical Society in the fall.

Dr. Thompson: There is one other point. We do not have the meeting in Milwaukee, as yet.

Speaker Stovall: We said, "If".

Dr. Thompson: That should be expressed.

Dr. Joseph Smith (Wausau): The meeting in New Orleans will not be held until April or May, and I presume that some tentative plan for the meeting of the State Society would have to be under way before that time, in case the House of Delegates of the American Medical Association should decide to go to Milwaukee.

Speaker Stovall: This is for 1933.

Dr. Stang: It seems if the state of Wisconsin could get the American Medical Association to meet in Milwaukee that everybody in the State Medical Society should certainly encourage Milwaukee in securing this, that we should dispense with our scientific program and support Milwaukee for this meeting. If we did have a regular session, there would be two big meetings in the year, probably both of them at Milwaukee and our state meeting certainly would suffer. I feel the State Society should support Milwaukee in trying to secure the American Medical Association, that we should dispense with the scientific program and have the regular business session at that time.

Dr. Cunningham: I believe, if we have the meeting in Milwaukee at the same time, it should be left to the discretion of the Program Committee as to what we should have beside our regular business. There might be some part of our regular state program that we would like to carry on beside the business part of the meeting. In that case, it should be left to the Program Committee, who would use judgment and discretion.

Dr. C. M. Gleason (Manitowoc): The united vote of the State Medical Society must mean something to the board of the American Medical Association. If we go before them with a quibble among ourselves, I think it is an argument against Milwaukee. Moreover, there is little doubt that practically all of the physicians who go to the convention would go to the American Medical Association in Milwaukee which means that the exhibitors would not feel it necessary to pay for space at our State Medical Society meeting should we have one that year which, as I understand, would cut off our revenue, which is no small matter.

Speaker Stovall: As I understand it, Dr. Gleason, the final resolution from this Society will be an unqualified invitation from this Society to the American Medical Association to come to Milwaukee. Any internal arrangement about transacting our business will be purely a personal affair for this Society, and would not be included in the recommendation of this Society to the American Med-

ical Association, except to say we will dispense with the regular meeting.

The question is on Dr. Gramling's amendment that the State Medical Society dispense with its annual meeting, which includes the scientific meeting but not the House of Delegates, the House of Delegates to meet at the time of the American Medical Association meeting in Milwaukee if it meets there.

Dr. Prentice: Would not it be better to have a resolution that the State Society conduct its regular state meeting in conjunction with the meeting of the American Medical Association and that the scientific program be dispensed with and the business meeting be held as regularly. In that way, we would have on record that we had our regular state meeting and not that the meeting had been dispensed with. I cannot see how you can say the state meeting has been dispensed with and the business meeting has been held.

Speaker Stovall: If Dr. Gramling will accept this modification, we can go through.

Dr. Gramling: It was worded better than I stated it.

Speaker Stovall: Now, then, we will have our regular meeting in conjunction with the American Medical Association meeting in June, if they meet there. The scientific program of the American Medical Association will be our program.

Dr. Krueger (Cudahy): What becomes of the financial support?

Dr. W. E. Bannen (La Crosse): At the meeting in Philadelphia, when this invitation was extended, the delegates from Wisconsin supported the Milwaukee proposition and talked to as many of the delegates as we could. We found the sentiment for the meeting in Milwaukee very good. The fact that there was a World's Fair at Chicago the same year, with crowded conditions in Chicago, and Milwaukee just around the corner, made a very favorable impression.

The representative from the Milwaukee Chamber of Commerce was there and spent three or four days making a very careful survey of the space required for the meeting of the American Medical Association. In checking over the facilities that Milwaukee had to offer, they were assured that there were ample facilities for the meeting of the American Medical Association.

The big fight will be on between Milwaukee and Cleveland, with Chicago having its hat in the ring, perhaps, in a half-hearted way. Chicago is going to be so crowded they would just as soon have the meeting in Milwaukee. That is the feeling we ascertained from the delegates at Philadelphia this year.

A good many of them had a little proviso that they wanted inserted in there, that Milwaukee would have its beer (Laughter) but, otherwise, the sentiment, as we found it, was very favorable for Milwaukee. I think there is a good chance for Milwaukee.

Speaker Stovall: Are you ready to vote on the amendment, as proposed by Dr. Gramling? All in favor say, "Aye"; contrary, "No". It is carried.

We have the matter relating to financial support.

Secretary Crownhart: The recommendation is: The question of contribution of funds from the treasury to help defray the expense of the Milwaukee Committee be referred to the Council for further consideration. It is the consensus of opinion of the committee that the State Society give the Milwaukee County Committee financial support in putting on the 1933 meeting of the American Medical Association in case it is to be held in Milwaukee.

Dr. C. J. Coffey (Milwaukee): It is now in order to vote on the amended resolution? We have carried the amendment, but we have not carried the resolution, as amended. This will be part of the resolution.

Speaker Stovall: This is the second amendment to the resolution. The second amendment to this resolution, as reported by the Committee, is that it be left to the discretion of the Council as to the amount of the contribution from the funds of this Society for the support of the American Medical Association meeting in Milwaukee, with the Milwaukee County Medical Society.

Dr. Gundersen: I move the adoption of this amendment.

. . . The motion was seconded by Dr. Thompson, of Milwaukee, and carried . . .

Speaker Stovall: We have before us the entire resolution, as amended. Are you ready for the question? All in favor say, "Aye"; contrary, "No". The resolution, as amended, is adopted.

It now stands that this Society unanimously invites the meeting of the American Medical Association to be held in Milwaukee in 1933 in conjunction with the Milwaukee County Medical Society, that we have our own business meeting at the time of the meeting of the American Medical Association, if it be so held in Milwaukee, and that it be left to the discretion of the Council as to the amount of the contribution of funds for the support of that project.

Secretary Crownhart: One sheet in the envelope of instructions to the Committee on Nominations has been lost. As a result, I learned that the committee did not nominate, as is the custom, a delegate to the American Medical Association to succeed Dr. Joseph F. Smith, of Wausau, and an alternate to succeed Dr. M. D. Bird, of Marinette. Will the members of the Nominating Committee remain in this room and come to the table immediately at the close of this meeting, so they may complete that section of their report? I am sorry the sheet was lost.

We have before us two amendments. First, an amendment to the Constitution which laid on the table since 1929 and which was read last night.

Amend Article IV of the Constitution, by adding a section to read Section 3. "Members in good standing who shall make outright gifts to the En-

dowment Fund of this Society, in the amount of $1,000 or more, shall have bestowed upon them the gift of life membership in this Society. Such membership shall carry with it all the prerequisites of active membership, without the requirements of annual dues, and shall continue in force during the life of the member, provided that the member continues in good standing in his local County Medical Society."

We are ready for a motion to accept this amendment.

Dr. Thompson (Milwaukee): I move the acceptance of this amendment to the Constitution.

. . . The motion was seconded by Dr. Higgins, of Milwaukee . . .

Dr. Mauermann: That does not include the County Society?

Speaker Stovall: No.

. . . The motion was carried . . .

Secretary Crownhart: Mr. Speaker, we have an amendment to the by-laws, introduced by the Chairman of the Council, speaking for the Council, at last night's session. Pursuant to the requirement of the by-laws themselves as relates to amendments, this amendment has laid on the table one day and is ready for action. Amend Chapter IX of the By-Laws of the State Society by adding a new paragraph to read:

"No member shall profess adherence or give support to any exclusive dogma, sect, or school."

Speaker Stovall: We are now ready to receive a motion for adoption.

Dr. Wenstrand: I move the adoption of the amendment.

. . . The motion was seconded by Dr. Redelings . . .

Speaker Stovall: Is it clear to you?

Secretary Crownhart: The By-Laws of our State Medical Society read, under Chapter IX, as follows: "The ethical principles governing the members of the American Medical Association shall govern members of this society." When we come back to the reading as to what are the ethical principles of the American Medical Association, as relates to the subject of one sect or school, we find that it says as follows: The obligation assumed on entering the profession requires the physician to comport himself as a gentleman and demands that he use every honorable means to uphold the dignity and honor of his vocation, * * * A physician should not base his practice on an exclusive dogma or sectarian system, for sects are despicable despots. To accept their thraldom is to take away all liberties from such action or thought."

There is considerable question as to whether that is a statement that a physician may not do those things, or simply there for guidance. The membership blank in a County Medical Society reads that the member makes application and, if accepted agrees to support the Constitution and By-Laws, "to practice in accordance with the established uses of the profession and will in no way profess adherence or give any support to any exclusive dogma, sect, or school." The Council recommends that practically the identical wording on our application blanks for membership be incorporated into our by-laws so that Chapter IX would read:

"No member shall profess adherence or give support to any exclusive dogma, sect, or school."

Dr. Boyd (Kaukauna): Would it not be well for the Secretary to state the purpose of this amendment? I think it was hinted at by the discussion of Dr. Rogers, in the report he made.

Secretary Crownhart: It was announced last night by Dr. Rogers, when he introduced it, as Chairman of the Council. It is already on the application blank and is simply to make it more forceful and enforceable.

Dr. Boyd: My thought was that this problem in the legislature, two years ago, was taken part in by some of our regular men. I presume this amendment referred to that issue.

Speaker Stovall: There may be some specific instances in mind. I do not know. I suppose it would be well to cull them, if that is the case. Is the question clear? All in favor of this motion say, "Aye"; contrary, "No". The motion is carried.

Secretary Crownhart: Mr. Speaker, that clears all the business on the Secretary's desk.

. . . General announcements . . .

. . . Adjournment at two forty-five p. m. . . .

(Adjournment)

THURSDAY AFTERNOON SESSION

September 10, 1931

The third session of the House of Delegates was called to order at two-fifteen p. m. by Dr. Stovall, the Speaker.

Speaker Stovall: We will have the report of the Committee on Credentials.

Dr. Henney: Mr. Speaker, there are registered at the desk: forty delegates, nine alternates, and fourteen officers. I move you that this constitutes the roll of this House of Delegates.

. . . The motion was seconded by Dr. S. M. B. Smith, of Wausau, and carried . . .

Secretary Crownhart: At the close of yesterday's session, Dr. Peterman, of Milwaukee, came to the Chair and said he had intended to discuss the Secretary's report and did not appreciate at the time it was before the House that opportunity was present for his discussion.

I would like to ask, with the unanimous consent of the House, that the Secretary's report be reopened for discussion.

Speaker Stovall: If I hear no objection to reopening consideration of the Secretary's report, we are now ready to receive discussion on that report, and we will consider it re-opened.

Dr. Peterman: I appreciate the courtesy of the Speaker and the Secretary, in re-opening the Secretary's report. I had intended to say something about the report and did not appreciate that the opportunity was passed.

Personally, I think it extremely unfortunate that our officers should see fit to entirely disregard the economic situation and to increase the budget, as it has been increased, according to the Secretary's report. Last year the dues were raised. Last year we lost 211 members; 216 are delinquent. I doubt whether we can forego the moral support of these men and of the group of young men to come into the State Society who cannot afford to belong to this Society, and I doubt whether their moral support is compensated for by the increased funds which we have.

Two years ago, when the matter of increase in dues was brought before this House of Delegates, one of the projects for which the dues were supposed to be increased was the medical editor. This House of Delegates went on record objecting to a medical editor. Last year we were told the increase in dues was not made to provide the medical editor. Three months later, the Council provided $2,500 in the budget for the medical editor of the Journal, regardless of the attitude of the House of Delegates.

Regardless of what we call this man who receives this $2,500 a year, he is, to all intents and purposes, the medical editor of the Journal. Possibly we need a medical editor. Possibly the majority of the Society want a medical editor. If so, I have nothing more to say.

However, I do believe that at this time, when all organizations and we, as individuals, are cutting our budgets to the bone, it is most inopportune to add $2,500 a year to the budget of the Journal, which is already running at a deficit and which will run at a deficit this year, in spite of the increase in dues.

I also question the advisability of adding to the Secretary's office $2,100 a year for an assistant secretary. I realize how much Mr. Crownhart has done. I appreciate his services. I know he is the best secretary perhaps in this country, but I doubt whether this is the opportune time to increase our budget to that extent.

I have another question. I have no doubt whatever of the ability of the man who was designated as medical editor. He has all the qualifications necessary, if we want a medical editor. I do ask, however, more confidently, as to a man who has a private practice and who has a half time position, how much time will he have left to give to the Journal than these men who have so kindly volunteered their services to the Editorial Board in the past.

Speaker Stovall: You have heard Dr. Peterman's discussion. Is there any further discussion of the Secretary's report? Dr. Peterman, do you care to make any motion?

Dr. Peterman: No.

Secretary Crownhart: Mr. Speaker, just so we will be under no misapprehension as to just what the situation is, I know that part of this is the result of misinterpretation of what we published in the Journal, for which the Secretary takes full responsibility. He did not appreciate it was susceptible to that interpretation.

The Council, at its 1931 January session, placed $2,500 at the disposal of the Editorial Board for the year, for the purpose of improving the Journal. Twenty-five hundred dollars has not been appropriated for a medical editor. A medical editor was secured. His services were secured in August, at an honorarium for the first year of fifty dollars a month, which amounts to $600, of which amount something less than one-half that will be used during the calendar year, 1931.

I have no comment to make on that, but want it perfectly clear before you as to how much has been spent for a medical editor and that the appropriation is from the general fund and will not increase the Journal deficit.

The Doctor is correct in stating that $2,100 was made available for an Assistant Secretary. We were unable to find one until May, when Miss Buellesbach came with the Society at a salary of $175 a month, which amounts to $2,100 a year. I just want that informational data to go into the report, so that no one is under any misapprehension. The Editorial Board will not use $2,500 this year. They will use, to improve the Journal and to meet the advertising deficit, not to exceed $1,000 total of the appropriation.

As to the membership, as stated in the Tuesday evening session, we now have 2,022 members as compared to 2,200 for all of last year. I doubt if the loss this year will be more than 100 of the anticipated 200.

Dr. Heidner: I do not think this subject should be passed over without any further discussion. As far as the Editorial Board appropriation is concerned, I do not think there was any idea in the Council that the $2,500 would be spent. I feel a little responsible in connection with the other proposition, because when the Budget Committee reported last year they had trimmed the budget quite materially. They questioned very much the proposition of an Assistant Secretary and had trimmed off a great many other things when this budget was discussed in the Council. My personal feeling on that was that the Secretary went around to all County Societies and the increase in dues was voted, not by the officers of the society, but it was voted practically by the individual members of such society throughout the state of Wisconsin. He was able to convince these members that the Society should carry on more work than it had been carrying on, and so they were in favor of increasing the dues.

We got the increase in dues, and the money is paid out of the pockets of the members. There are two things to do. We can cut down the budget and build up a surplus. After the dues had been raised, the money came in. We would not put money back into anybody's pocket by cutting down the budget, because the money was paid into the treasury.

It seems to me, at a time of depression, as we are having now, if there is any effect on the progress of state medicine, or the socailization of medicine, it would move forward in a time like this more than at any other time. In the first place, medical fees are more of a burden than they are during flourishing times. There is more charity work done, and the people throughout the state, especially in the larger centers, are getting a taste of free medical service which they never had before. If they like it, when times get better they will probably want to retain it or increase that free medical service.

I feel whatever work the State Society can do in protecting the medical profession is much more important right now than it is during a time when everybody is flourishing and the cost of medical care does not cut much figure in their family budget. That is the reason why I, for one, was in favor of giving the Secretary more time to get out and study the problem of the medical profession, and try to give a solution at this time.

I did not feel it was the proper time to increase the surplus and put it back, when the individual members of the Society had voted that they wanted to pay this for additional service.

As far as the Editorial Board proposition is concerned, we felt the men on the Editorial Board had been working, at a great sacrifice of time, and felt probably with some stimulus in the way of prizes or some other way to get men to work and write articles, we could probably improve it a little. As far as I am concerned, I think the Journal is good. I have had inquiries in my district about the Journal, and I believe the Wisconsin Journal is being read more by the average man in the state than it was ever read before. I, personally, would be very much against changing the type of articles in the Journal. I think by making it more or less of a family affair, where the men pick it up for the personal items, they become interested and read it from cover to cover more than they ever did. I would be very much against making the Journal too scientific, going into the scientific side of medicine, away from the practical side by hiring a highly scientific editor for the Wisconsin Medical Journal.

Dr. Joseph F. Smith (Wausau): On behalf of the Editorial Board, I wish to say there has been a good deal of talk about the Journal, some criticism. This matter has been discussed during the last two or three years, and the question has been brought up as to the advisability of having some additional help. The Council finally made available to the Editorial Board the sum of $2,500 to be used, at its discretion, in securing additional help. That money was made available some time ago, but on account of the fact we were not able to find anybody to fill the place right away, nothing was done about it until recently, when a man was secured at a salary or honorarium of $600 a year, fifty dollars a month, to spend part of his time in helping with the editorial work.

This, as I say, has not gone into effect. The arrangement has just been made, and if the House of Delegates feels this is an unwarranted expenditure and this feature is not wise, now is the time to say so. The Editorial Board would like very much to have an expression on this question, as to whether you approve that expense. We do not like to go ahead if there is any considerable opposition on the part of the delegates. On the other hand, if you feel that is the proper thing to do, we will carry out your wishes in the matter.

Speaker Stovall: Gentlemen, let us have this proposition clear. We are not going to get anywhere by discussing the matter. There is no desire to cut off discussion, but if at the end of this time there is no motion before the House for us to consider, I think it is time to close the discussion.

Dr. Duer (Marinette): I make a motion that we approve the action of the Council and the Editorial Board, in regard to selecting an assistant editor.

. . . The motion was seconded by Dr. Arveson, of Frederic . . .

Speaker Stovall: There is a motion to approve the action of the Council and Editorial Board in selecting an assistant for the editing of the Journal, who is to receive an honorarium of $600 a year. It is open for discussion.

. . . The question was called for . . .

Speaker Stovall: Are you sure you want the question? I would like to hear some discussion. If there is no discussion, the question will be put.

Dr. Prentice: What is to be done with the balance of the $2,500?

Secretary Crownhart: It reverts to the general fund, available for further appropriation by the Council for whatever purpose they see fit.

Dr. Beebe: That is not a continuing appropriation. That $2,500 is appropriated but not with the idea that it has to be spent in one year. Supposing $100 is left over, is it the idea next year the Council will recommend an appropriation of $2,500, so that is a continuing $2,500 appropriation?

Secretary Crownhart: That is not my understanding, Dr. Beebe. The Editorial Board, if they desire to continue the medical assistant to the Board, may come to the Council and ask for $600 or whatever honorarium they desire to suggest. That which is left over this year reverts to the general fund and is at the disposal of the Council for whatever purpose they see fit to make of it, and does not continue for the disposal of the Editorial Board.

Dr. Peterman: I did not wish to make a motion and did not introduce a resolution. I discussed the matter with a number of the delegates and one Councilor and no one seemed to be aware of the situation until Mr. Crownhart explained the $2,500 a few minutes ago. That is the first idea I had of the situation. However, in the matter of piling up funds, the Journal ran at a deficit last year and will have another deficit next year.

I might offer this statement as a criticism. If

the entire House of Delegates votes to approve this action, I stand in the minority, as I did in the increase of dues, and have nothing further to say.

Speaker Stovall: The question is the approval of the action of the Council and Editorial Board in securing an assistant scientific editor at an honorarium of $600 a year. All in favor of the motion will vote, "Aye"; contrary, "No". The motion is carried.

Secretary Crownhart: If there are any other suggestions or discussions on the Secretary's report or the budget as a whole, I hope no delegate will refrain from presenting his views. I think I said to this House a year ago, and possibly a year before that, as far as the full time officer of your Society is concerned, he has no preconceived ideas. He is trying to suggest that action which, in his mind, might best benefit the State Society. He is perfectly frank to state all his suggestions were not accepted in the past, and many times should not have been accepted, as was proved later. Anything this House wishes, your Secretary will carry out to the best of his ability, for the State Medical Society is governed by this House of Delegates, and your Secretary will govern his actions accordingly, as you suggest, or as the Council suggests, in the interim when the House is not in session.

I hope no delegate, at this time, or any other time, will hestitate to ask the question Dr. Peterman has asked or any others. They are not only entitled to present their views but as delegates have an obligation so to do, and I assure you it is very helpful in administering the work of the Society along the lines, whatever they may be, that you may dictate.

Speaker Stovall: I believe that completes discussion on the Secretary's report, and we will pass on.

Dr. Joseph F. Smith: I got in late and did not understand whether anything was done with that part of the delegate's report that dealt with Dr. Shoulders' resolution, requesting the State Medical Society to cooperate in the bill before Congress in the matter of increase of veterans' hospitals. I think that is a matter of some importance.

Secretary Crownhart: The report of the Committee on Officers Reports is not before me, but I can assure you, Dr. Smith, action was taken to extend full cooperation by committees or in any way the Council saw fit, and immediate action.

Speaker Stovall: The next order of business is the report of the Committee on Nominations.

Secretary Crownhart: Dr. Gates, of Tigerton, has presented this report. May I make the usual statement before opening this report, that the nominations of the Committee on Nominations do not preclude any additional nominations from the floor for any office, if the delegates see fit to make such additional nominations.

Mr. Speaker, the following is the report of the Committee on Nominations, signed by all twelve members of the committee.

Alternate delegates to the American Medical Association to succeed Dr. M. D. Bird, Dr. Bird to succeed himself.

Delegate to the American Medical Association to succeed Dr. Joseph F. Smith, of Wausau, Dr. Smith to succeed himself.

Place of 1932 annual meeting is left blank, and in that event, following the usual custom, it will go to Milwaukee, unless otherwise directed by the House.

Vice-Speaker to succeed Dr. H. M. Stang, of Eau Claire, Dr. M. D. Bird, of Marinette.

Speaker of the House of Delegates, to succeed Dr. W. D. Stovall, of Madison, Dr. Stanley Seeger, of Milwaukee.

President-Elect, Dr. Reginald H. Jackson, Madison.

Speaker Stovall: The report of the Committee on Nominations is now before you. I would like to have a motion for the adoption of this report.

Dr. Mauermann: Mr. Speaker, I move that the report be adopted.

. . . The motion was seconded by Dr. Krueger, of Cudahy . . .

Speaker Stovall: Are there any other nominations for these offices * * * All in favor of the adoption of this report, say, "Aye". contrary, "No". The motion is carried and the report of the Nominating Committee has been adopted.

Secretary Crownhart: Mr. Speaker, this clears the business on the desk of the Secretary unless there is new business to come before us at this time. This is the final meeting of the House of Delegates.

Speaker Stovall: Dr. Fiedler, would you like to make some remarks to the House before we close this year's session?

President-Elect Fiedler: I have nothing to say.

Speaker Stovall: I would like to say to the House of Delegates, before we adjourn, I am quite appreciative of the compliment paid me by electing me speaker of the House. I enjoyed my duties and have enjoyed seeing you all. I wish you much success and thank you for the honor.

If there is no further business and I hear no objection, the House of Delegates is adjourned.

. . . Adjournment at two forty-five p. m. . . .

(Adjournment)

Attendance House of Delegates, Madison 1931

Society	*Delegate*	*1*	*2*	*3*
Ashland–B–I	J. W. Prentice, Ashland	a	x	x
	J. M. Dodd, Ashland*	a	a	x
Barron–W–S–B	D. L. Dawson, Rice Lake	a	a	a
Brown–Kewaunee	R. M. Carter, Green Bay	x	x	x
Calumet	J. W. Goggins, Chilton	a	a	a

Chippewa	A. J. Somers, Chippewa Falls	a	a	a
	C. B. Hatlberg, Chippewa Falls*	x	x	a
Clark	H. H. Christofferson, Colby	x	x	x
Columbia	C. W. Henney, Portage	x	x	x
	H. E. Gillette, Pardeeville*	x	a	a
Crawford	F. J. Antoine, Prairie du Chien	a	a	a
	C. A. Armstrong, Prairie du Chien*	x	a	x
Dane	W. F. Lorenz, Madison	x	x	x
	A. S. Thompson, Mt. Horeb	a	x	x
	L. W. Peterson, Sun Prairie*	x	x	x
Dodge	E. P. Webb, Beaver Dam	x	x	x
Door				
Douglas	T. J. O'Leary, Superior	x	x	x
Eau Claire & Associated	F. C. Kinsman, Eau Claire	x	x	a
	F. E. Butler, Menomonie	x	x	x
Fond du Lac	S. E. Gavin, Fond du Lac	x	x	x
Grant	E. H. Spiegelberg, Boscobel	x	x	x
Green	J. F. Mauermann, Monroe	x	x	x
Green Lake–W–A	A. J. Wiesender, Berlin	x	x	a
Iowa	H. M. Walker, Dodgeville	a	a	a
Jefferson	H. P. Bowen, Watertown	x	a	x
	W. S. Waite, Watertown*	x	x	x
Juneau	C. C. Vogel, Elroy	x	x	a
Kenosha	J. H. Cleary, Kenosha	a	a	a
La Crosse	Gunnar Gundersen, La Crosse	x	x	x
Lafayette	P. W. Leitzell, Benton	x	x	a
Langlade	J. C. Wright, Antigo	x	x	x
Lincoln	E. O. Ravn, Merrill	x	x	a
Manitowoc	C. M. Gleason, Manitowoc	x	x	x
Marathon	S. M. B. Smith, Wausau	x	x	x
Marinette–Florence	G. R. Duer, Marinette	x	x	x
Milwaukee	W. M. Kearns, Milwaukee	a	a	a
	M. G. Peterman, Milwaukee	x	x	x
	Bernard Krueger, Cudahy	x	x	x
	S. G. Higgins, Milwaukee*	x	x	a
	F. A. Thompson, Milwaukee	x	x	x
	A. A. Pleyte, Milwaukee*	x	x	a
	E. F. Peterson, Wauwatosa	a	a	a
	D. E. W. Wenstrand, Milwaukee	x	x	x
	Edith McCann, Milwaukee	x	a	x
	J. O. Dieterle, Milwaukee	x	x	a
	Oscar Lotz, Milwaukee*	x	x	a
	E. W. Miller, Milwaukee	x	a	x
	F. D. Murphy, Milwaukee*	a	x	a
	S. J. Seeger, Milwaukee	a	a	a
	H. C. Schumm, Milwaukee*	a	a	x
	H. J. Gramling, Milwaukee	x	x	x
	H. W. Powers, Milwauke	x	x	a
	G. W. Neilson, Milwaukee*	a	a	x
	R. E. Fitzgerald, Milwaukee*	x	x	a
	C. J. Coffey, Milwaukee	a	x	a
	F. J. Gaenslen, Milwaukee*	x	x	a
Monroe	A. E. Winter, Tomah	x	x	x
Oconto	J. S. Dougherty, Suring	a	x	x
Oneida–F–V	I. E. Schiek, Rhinelander	x	x	x
Outagamie	C. D. Boyd, Kaukauna	x	x	x
Pierce–St. Croix	A. E. McMahon, Glenwood City	x	x	x
Polk	R. G. Arveson, Frederic	x	x	x
Portage	E. P. Crosby, Stevens Point	a	a	a
	E. E. Kidder, Stevens Point*	x	x	a
Price–Taylor	F. W. Mitchell, Medford	x	x	x
Racine	H. B. Keland, Racine	x	x	x
Richland	Gideon Benson, Richland Center	x	x	x
	C. F. Dull, Richland Center*	x	x	x
Rock	Wm. J. Allen, Beloit	x	x	a
	H. O. Delaney, Beloit*	x	a	a
Sauk	H. J. Irwin, Baraboo	a	a	a
Shawano	Adam J. Gates, Tigerton	x	x	x
Sheboygan	R. C. Meyer, Plymouth	x	x	x
Treampealeau–J–B	C. F. Peterson, Independence	x	x	x
	H. A. Jegi, Galesville*	x	a	x
Vernon	W. H. Remer, Chaseburg	a	x	x
Walworth	T. L. Jacobson, Delavan	x	x	a
Washington–Ozaukee	H. M. Lynch, Milwauke	x	x	a
Waukesha	H. T. Barnes, Delafield	x	x	x
Waupaca	F. E. Chandler, Waupaca	a	a	a
Winnebago	J. W. Lockhart, Oshkosh	x	x	x
Wood	F. X. Pomainville, Wis. Rapids	a	a	a
	K. H. Doege, Marshfield*	a	x	x

District	Councilor	1	2	3
First	A. W. Rogers, Oconomowoc	x	x	x
Second	Frank W. Pope, Racine	x	x	x
Third	C. A. Harper, Madison	x	x	x
Fourth	Wilson Cunningham, Platteville	x	x	x
Fifth	A. H. Heidner, West Bend	x	x	x
*Sixth	F. Gregory Connell, Oshkosh	x	x	a
Seventh	S. D. Beebe, Sparta	x	x	x
Eighth	T. J. Redelings, Marinette	x	x	x
Ninth	Joseph F. Smith, Wausau	x	x	x
Tenth	H. M. Stang, Eau Claire	x	x	x
Eleventh	F. G. Johnson, Iron River	x	x	x
Twelfth	R. W. Blumenthal, Milwaukee	x	x	x

(*) Indicates alternates; (x) present; (a) absent.

* Sixth: Dr. S. E. Gavin, Fond du Lac, was elected councilor for this District at the second meeting of the House of Delegates and was present at the third meeting.

Council Meeting

Memorial Union Building, Madison

Tuesday, Sept. 8, 1931

1. The Council was called to order at 1:15 Tuesday afternoon, September 8th, with the Chairman, Dr. A. W. Rogers, Oconomowoc, in the chair. Roll call showed all present.
2. It was moved by Dr. Blumenthal, seconded by Dr. Cunningham, that the report of the auditors for the accounts of the Secretary-Managing Editor and Treasurer for the year 1930 as published in the Wisconsin Medical Journal for August, 1931, be approved. Carried.
3. It was moved by Dr. Fiedler, seconded by Dr. Harper, that the Society waive collection of dues for a member of the Barron–Washburn–Sawyer–Burnett County Medical Society, check of which Society was found uncollectable because of closure of bank, tying up the Society's funds.
4. Without dissent, the following mail votes of the Council were confirmed:
   a. Granting the 1931 council awards to Drs. Edward Evans, La Crosse; Louis F. Jermain, Milwaukee, and John Joseph McGovern, Milwaukee.
   b. Granting permission to the Secretary to become Secretary of the Wisconsin Hospital Association, compensation to be paid to the State Society rather than to the Secretary.
5. Discussion of a news story prepared by the Secretary for the lay press on the services of the general practitioner. Approval rejected, 4–7.
6. Secretary reported that an editorial on "Sects in Medicine" had been approved by the Council by a vote of 9 to 2, but publication had been withheld to await further discussion. After discussion it was moved by Dr. Connell, seconded by Dr. Fiedler, that the editorial be withheld but that the Council recommend to the House of Delegates the following amendment to the By-Laws:

   Amend chapter IX of the By-Laws of the State Medical Society of Wisconsin by adding a new paragraph to read: "No member shall profess adherence or give support to any exclusive dogma, sect, or school."

   Carried.
7. Due to the fact that two appropriations for the calendar year 1932 must be made available before the next meeting of the Council, the Secretary asked that the following projects be approved:
   a. $450 for subscriptions to Hygeia (same as 1931).
   b. $1,000 for 1932 Secretaries' Conference (same as 1931).
   a. Following discussion it was moved by Dr. Smith, seconded by Dr. Pope, that the appropriation of $450 for subscriptions to Hygeia in 1932 be approved. Carried.
   b. It was suggested by Dr. Sleyster that in non-legislative years, the Secretaries' Conference be held on the afternoon prior to the first day of the scientific sessions of the annual meeting with the Council meeting in the forenoon. On that basis, it was moved by Dr. Smith, seconded by Dr. Blumenthal, that an appropriation of $300 for the 1933 Secretaries' Conference be allowed. Carried.
8. The Secretary made a preliminary report on the receipts and expenditures of the Beaumont Memorial Committee. A final report will be made at the January Council meeting.
9. Dr. Blumenthal reported as the Chairman of the Special Committee on Foundation Fund, whose other members are Drs. Sleyster and Gaenslen. The Committee submitted a proposed declaration of trust with the First Wisconsin Trust Company. After thorough discussion it was moved by Dr. Blumenthal, seconded by Dr. Stang, that this declaration be laid on the table until the January meeting and that in the interim a copy be forwarded to every member of the Council. Carried.

10. It was moved by Dr. Connell, seconded by Dr. Redelings, that Dr. G. J. Kaumheimer of Milwaukee be elected an honorary member of the State Medical Society of Wisconsin. Carried.

11. The Secretary reported that in his opinion need existed presently for a new model constitution and by-laws for the proponent county medical societies. It was moved by Dr. Fiedler, seconded by Dr. Blumenthal, that the Chairman of the Council be authorized to appoint a special committee for such purpose and that an appropriation of $100 be made to the Committee for such legal expense as might be incurred. Carried. The Chairman appointed Drs. Fiedler, Sleyster, and Heidner as members of this Committee.

12. The Secretary suggested to the Council that, pursuant to its powers under Chapter II, Section 3 of the By-Laws, the Council recommend to a component society that it take immediate action to ascertain the truthfulness of certain charges made against Member A with the request for his expulsion, should the charges be proved true or not denied.

    Statement of the case: Dr. A. is hired on a salary by Drs. B. and C. Dr. A., finding and attractive opening elsewhere, leaves B. and C. with their consent and without ill feeling. His secretary is his sister-in-law, who also removed with Dr. A. and his family. Following removal of household effects, Dr. A. goes to Madison for the ten-day postgraduate course under Dr. Hasslinger.

    While Dr. A. is in Madison Dr. Z., residing in the same community as B. and C., writes the secretary of Dr. A. that he (Z) will pay the secretary $50 if she will sign and mail from the new town a letter to Dr. A's old patients as purporting to come from Dr. A. and recommending to such former patients that they henceforth secure the services of Dr. Z. The secretary, being in need of money, accepts the offer, advises Z of the numbers and names and addresses of such patients, Z has the letters printed, envelopes addressed, forwards them to the secretary of A who signs them with A's name and her initials and then mails them from the new location to A's former patients. Your Secretary receives copies of these letters from members who inquire if it is ethical. Subsequent correspondence then discloses this state of affairs and is supported by affidavits of A's secretary, Dr. A., and the printer. These affidavits were read at the meeting.

    It was moved by Dr. Fiedler, seconded by Dr. Smith, that this be brought to the attention of the county medical society involved with the request that they institute an immediate investigation and in event that the charges be found true that the Society take suitable action. Carried.

13. The Secretary reported that following the six one-day centers on the subject of Insulin, he had queried some fifty members in the several sections of the state as to the value of the special course and that with one exception all forwarded enthusiastic responses. Dr. Johnson suggested that if this be repeated with other subjects that Madison be dropped and that Superior be substituted. Dr. Heidner suggested as a future subject "Diagnosis and Indications For Operation in Acute Surgical Conditions." Dr. Smith suggested as a future subject "Fractures." It was moved by Dr. Connell, seconded by Dr. Redelings that it is the sense of the Council that courses similar to that on Insulin be instituted from time to time if it is deemed advisable by the Committee on Medical Extension. Carried.

14. The Secretary read a communication from Dr. W. C. Woodward, director of the Bureau of Legal Medicine of the American Medical Association, suggesting support for legislation to create a state criminologic institute. Following discussion, it was moved by Dr. Sleyster, seconded by Dr. Fiedler, that the Secretary write the State Bar Association that inasmuch as this report came from a joint national committee of the Bar and the American Medical Association, that the State Medical Society offers to take part in accomplishing state enactment through a joint committee of the State Bar Association and the State Medical Society. Carried.

15. A half hour was devoted to a general discussion on the status of membership. It was the concensus of opinion of all that high standards of membership are preferable to members and that while every effort should be made to include all ethical practicing physicians in the membership of the Society, every attention should be given that none but those qualified be permitted to join.

16. The Secretary requested a special committee for the purpose of investigating the subject of corporate practice. It was moved by Dr. Blumenthal, seconded by Dr. Harper, that the chairman of the Council be instructed to appoint such committee. Carried. The Chairman announced the appointment of Drs. Pope, Redelings and Blumenthal to constitute the committee.

17. Dr. Johnson submitted a resolution on diet fads received from the National Food Bureau. Following discussion the resolution was unanimously rejected.

18. Dr. Johnson reported on the difficulties in holding a district meeting in the 11th district because of the large territory involved. It was the concensus of opinion that the several societies of the district be queried as to their desires.

19. There being no further business on the Secretary's desk, the Council adjourned at 5:15 P. M.

SUBSEQUENT MEETINGS

Pursuant to the constitution, the Council met on Wednesday and Thursday, September 9 and 10, following each session of the House of Delegates. There being no further business coming before the Council, each session was adjourned without formal transactions.

J. G. Crownhart.

Approved:
A. W. Rogers, M. D.
Chairman of Council.

Officers---Committees, State Medical Society

Elected by House of Delegates: President, president-elect, vice-speaker and councilors. Elected by Council: Secretary and Treasurer. Appointed by president-elect: One member on each standing committee to serve a three-year term.

President:
Otho A. Fiedler, Sheboygan---Sept., 1932

President-Elect:
Reginald A. Jackson, Madison-Sept., 1932

Secretary:
J. G. Crownhart, Madison-----Jan., 1932

Treasurer:
Rock Sleyster, Wauwatosa-----Jan., 1932

Speaker:
Stanley J. Seeger, Milwaukee--Sept., 1932

Vice-Speaker:
M. D. Bird, Marinette--------Sept., 1932

Delegates to American Medical Association:
Joseph F. Smith, Wausau-------Sept., 1933
J. Gurney Taylor, Milwaukee----Sept., 1932
W. E. Bannen, La Crosse--------Sept., 1932

Alternate delegates:
F. Gregory Connell, Oshkosh----Sept., 1932
T. W. Nuzum, Janesville--------Sept., 1932
M. D. Bird, Marinette----------Sept., 1933

COUNCILORS

First: Dodge, Jefferson and Waukesha County Societies. A. W. Rogers, Oconomowoc, 1933.

Second: Kenosha, Racine and Walworth County Societies. F. W. Pope, Racine, 1933.

Third: Dane, Columbia, Green, Rock and Sauk County Societies. C. A. Harper, Madison, 1934.

Fourth: Crawford, Grant, Iowa, LaFayette and Richland County Societies. Wilson Cunningham, Platteville, 1934.

Fifth: Calumet, Manitowoc, Washington–Ozaukee and Sheboygan County Societies. A. H. Heidner, West Bend, 1934.

Sixth: Brown–Kewaunee, Door, Outagamie, Fond du Lac and Winnebago County Societies. S. E. Gavin, Fond du Lac, 1934.

Seventh: Juneau, La Crosse, Monroe, Trempealeau–Jackson–Buffalo and Vernon County Societies. S. D. Beebe, Sparta, 1932.

Eighth: Marinette–Florence, Oconto and Shawano County Societies. T. J. Redelings, Marinette, 1932.

Ninth: Clark, Green Lake–Waushara–Adams, Lincoln, Marathon, Portage, Waupaca and Wood County Societies. Joseph F. Smith, Wausau, 1932.

Tenth: Barron–Washburn–Sawyer–Burnett, Polk, Chippewa, Eau Claire and Associated Counties and Pierce–St. Croix County Societies. H. M. Stang, Eau Claire, 1932.

Eleventh: Ashland–Bayfield–Iron, Douglas, Langlade, Oneida–Forest–Vilas and Price–Taylor County Societies. F. G. Johnson, Iron River, 1933.

Twelfth: Milwaukee County Society. R. W. Blumenthal, Milwaukee, 1933.

COMMITTEES

1. The Committee on Scientific Work:
   T. L. Squier, Milwaukee, Chm., 1934
   Arthur G. Sullivan, Madison, 1933
   W. S. Middleton, Madison, 1932
2. The Committee on Public Policy:
   Otho Fiedler, Sheboygan, Chm., 1933
   R. A. Jackson, Madison, 1934
   S. M. B. Smith, Wausau, 1932
3. Editorial Board:
   Oscar Lotz, Milwaukee, Chm., 1933
   H. P. Greeley, Madison, 1934
   Joseph F. Smith, Wausau, 1932
4. The Committee on Medical Defense:
   A. J. Patek, Milwaukee, Chm., 1933
   Arthur G. Sullivan, Madison, 1934
   W. C. Becker, Watertown, 1932

5. The Committee on Medical Education and Hospitals:
   C. R. Bardeen, Madison, Chm., 1933
   Joseph W. Lambert, Antigo, 1934
   F. D. Murphy, Milwaukee, 1932
6. The Committee on Medical Economics:
   V. F. Marshall, Appleton, Chm., 1934
   J. F. Mauermann, Monroe, 1933
   T. D. Smith, Neenah, 1932
7. The Committee on Health and Public Instruction:
   W. D. Stovall, Madison, Chm., 1933
   H. M. Stang, Eau Claire, 1934
   C. M. Gleason, Manitowoc, 1932
8. The Committee on Necrology:
   Councilors and Secretary
9. Advisory Committee on Medical Extension:
   Gunnar Gundersen, La Crosse, 1935
   K. H. Doege, Jr., Marshfield, 1936
   M. D. Bird, Marinette, 1932
   A. J. Wiesender, Berlin, 1933
   J. F. Wilkinson, Oconomowoc, 1934

MEMBERSHIP, STATE MEDICAL SOCIETY OF WISCONSIN

(As of December 1, 1931)

Abbotsford:
Jandrain, R. R.

Adell:
Bemis, Ira M.

Albany:
Cox, A. M.
Lemmel, J. T.

Algoma:
Foshion, H. V.
Witcpalek, W. W.

Allenton:
Fisher, R. S.

Almena:
Arneson, Thomas

Almond:
Meyer, M. W.

Amery:
Cornwall, W. B.

Amherst:
Schlenker, G. H.
Webster, F. E.

Antigo:
Bloor, E. G.
Dorzeski, E. F.
Donohue, E. J.
Donohue, M. J.
Flatley, M. A.
Lambert, J. W.
McKenna, E. A.
Moore, G. E.
Steffen, L. A.
Wright, J. C.
Zellmer, C. E.

Appleton:
Bolton, E. L.
Benton, J. L.
Brooks, E. H.
Carlson, G. W.
Cooney, E. W.
Dehne, W. O.
Dohearty, F. P.
Frawley, D. D.
Gallaher, D. M.
Harrington, Wm. J.
Hegner, G. T.
Huberty, F. J.
Landis, R. V.
MacLaren, J. B.
Marshall, V. F.
McGrath, E. F.
Mielke, E. F.
Millard, A. L.
Mills, N. P.
Neidhold, C. D.
Pardee, C. A.
Rector, A. E.
Reeve, J. S.
Reineck, Chas.
Ritchie, G. A.
Ryan, C. E.

Arcadia:
Comstock, E.
Palmer, J. A.
Weber, F. T.

Argyle:
Slemmons, T. M.
Williams, W. B.

Arlington:
Reagles, Robt.

Ashland:
Andrus, A. D.
Dodd, J. M.
Dodd, J. M., Jr.
Grigsby, R. O.
Hertzman, C. O.
Hosmer, M. S.
Kamm, A. X.
Prentice, J. W.
Sandin, N. V.
Shaw, A. O.
Smiles, C. J.
Tucker, W. J.
Young, M. L.

Athens:
Frick, Lewis

Augusta:
Prill, H. F.
Winter, E. H.

Baldwin:
Kunny, B.
Swenson, G. B.

Bangor:
Ruppenthal, K. P.
Ward, M. W.

Baraboo:
Cahoon, Roger
Edwards, A. C.
Farnsworth, A. L.
Irwin, H. J.
Kelly, D. M.
McGrath, E.
Moon, J. F.
Snyder, A. F.
Tryon, F. E.

Barron:
Coleman, H. M.
Galloway, A. D.
Post, C. C.
Ruethin, K. A.
Schlomovitz, H. H.

Barton:
Driessel, S. J.

Bayfield:
Mertens, H. G.
Shumate, J. K.

Beaver Dam:
Corso, Xavier
Hammond, A. W.
Holtz, H. M.
Hoyer, A. A.
Hoyer, G. H.
O'Hora, C. M.
Riopelle, W. G.
Roberts, R. R.
Rosenheimer, A. M.
Schoen, R. E.
Webb, E. P.

Belmont:
Hubenthal, J. C.

Beloit:
Allen, Jessie P.
Allen, W. J.
Brinckerhoff, F. E.
Brown, E. B.
Burger, H. E.
Crockett, W. W.
Crone, V. D.
Curless, Grant R.
Dawson, C. N.
Flarity, T. H.
Fosse, B. O.
Fox, P. A.
Friend, L. J.
Helm, A. C.
Helm, H. M.
Kasten, H. E.
Keithley, J. W.
Leeson, F. W.
Maurer, H. C.
Ottow, A. F.
Raube, H. A.
Schram, C. F. N.
Shinnick, T. F.
Smith, C. E.
Thayer, F. A.
Zwaska, A. B.

Benton:
Leitzell, P. W.

Berlin:
Casper, S. L.
Scott, B. E.
Wiesender, A. J.

Birchwood:
Ainsworth, H. H.

Birnamwood:
Stauff, G. R.

Black Creek:
Laird, J. J.

Black River Falls:
Domine, A. Z.

Blair:
Richards, R. R.

Bloomer:
Fortner, W. H.
Hudek, D. F.
Trankle, H. M.

Bloomington:
Baldwin, F. H.
Glasier, M. B.
Harris, C. F.
McLaughlin, H. J.

Blue Mounds:
Bancroft, H. V.

Blue River:
Randall, M. W.

Bonduel:
Terlinden, J. H.

Boscobel:
Betz, J. C.
Freymiller, E. F.
Hayman, C. S.
Spiegelberg, E. H.

Boyceville:
Williams, A. E.

Brandon:
Shaykett, F. E.
Shepard, E. L.

Brillion:
McComb, I. N.

Brodhead:
Darby, G. S.
Fleek, J. L.
Mitchell, E. J.
Ross, M. E.
Taylor, A. R.

Brookfield:
Nixon, R. T. A.

Brooklyn:
Gray, Rodney J.

Brownsville:
Fuller, J. D.
Raymond, R. G.

Bruce:
Prentiss, Pearce

Burlington:
Bennett, J. F.
Flaherty, G. S.
Fulton, W. A.
Newell, F. F.
Newell, G. W.
Prouty, W. A.

Cable:
Clark, Kate

Cambria:
Williams, W. E.

Cambridge:
Amundson, K. K.
Bilstad, G. E.

Campbellsport:
Guenther, O. F.
Hoffmann, L. A.

Casco:
Fencil, Y. J.
Kerscher, E. J.

Cashton:
Cremer, C. H.
Mauel, N. M.

Cassville:
Blackburn, F. E.
Houghton, E. M.

Cato:
Guttman, Paul
Kelley, J. M.

Cazenovia:
Hanko, J. E.

Cedarburg:
Hurth, O. J.
Katz, H. M.
Warnshuis, G. J.

Cedar Grove:
Van Altena, L. A., Jr
Voskuil, A.

Centuria:
Noyes, G. B.

Chaseburg:
Remer, W. H.

Chetek:
Adams, R. W.

Chilton:
Goggins, J. W.
Knauf, N. J.
Minahan, J. J.
Rathert, E. T.

Chippewa Falls:
Beier, A. L.
Ellenson, E. P.
Field, Merton
Hatleberg, C. B.
Henske, W. C.
Kelly, J. A.
McCarty, E. O.
McHugh, F. T.
McRae, J. D.
Myre, Charles F.
Schuster, B. L.
Schwartz, R.
Somers, A. J.
Williams, S. E.

Clear Lake:
Campbell, L. A.
Nelson, A. N.

Cleveland:
Reinert, E. N.

Clinton:
Dodge, C. H.
Parker, A. S.
Thomas, W. O.

Clintonville:
Finney, W. H.
Miller, E. A.
Murphy, J. H.
Walch, F. C.

Cobb:
Morton, H. H.

Colby:
Christofferson, H. H
Schemmer, A. L.

Coleman:
Graner, L. H.

Colfax:
Cooper, C. A.
Felland, O. M.

Columbus:
Bellack, B. F.
Caldwell, H. M.
Mudroch, J. A.
Poser, E. M.
Schmeling, A. F.

Coon Valley:
Solberg, A. A.

Cornell:
Foster, J. H. A.

Crandon:
Decker, C. O.
Ison, G. W.

Cross Plains:
Froggatt, W. E. L.

Cuba City:
Bair, F. M.
Donnell, J. E.
Terry, R. E.

Cudahy:
Fine, J. M.
Krueger, B.
Partridge, C. D.
Sidler, A. C.
Smith, H. S.

Cumberland:
Babcock, I. G.
Grinde, G. A.
Lund, S. O.

Dale:
Archer, W. E.

Darien:
O'Brien, H. N.

Darlington:
Orton, Susanne
Quinn, R. B.

De Forest:
Bertrand, J. H.

Delafield:
Barnes, H. T.

Delavan:
Bachelle, C. V.
Crowe, N. F.
Doughty, J. W.
Jacobson, T. L.
Rice, F. A.
Wright, C. A.

Denmark:
Hager, F. J.
Vosburgh, W. H.

De Pere:
Kersten, N. M.
Lenfestey, J. P.

DeSoto:
Myrick, A. L.

Dodgeville:
Hagerup, T. A.
Hamilton, D. B.
Pearce, W. J.
Reese, William
Walker, H. M.

Dorchester:
Foley, F. P.

Dousman:
Schneider, Hans

Durand:
Schulberg, P. A.

Eagle River:
Oldfield, R. A. A.

East Troy:
Meany, S. G.
Mullen, R. A.
O'Leary, T. J.

Eau Claire:
Anderson, F. G.
Baird, J. C.
Beebe, G. W.
Cook, F. S.
Derge, H. F.
Falstad, C. H.
Flynn, L. H.
Goddard, J. B.
Guyton, E. A.
Haag, A. F.
Hayes, E. P.
Hayes, E. S.
Henke, Samuel L.
Hoyme, G.
Johnson, Fred
Kinsman, F. C.
LaBreck, F. A.
Malone, J. Y.
Manz, Walton R.
Mason, E. L.
Midelfart, H. C. U.
Mitchell, R. E.
Payne, A. L.
Scullard, G.
Seemann, W. O.
Spelbring, P. G.
Stang, H. M.
Stoland, I.
Tanner, J. W.
Tupper, E. E.
Werner, Nels
Werner, R. F.
Ziegler, J. E. B.

Eden:
Hardgrove, J. H.

Edgar:
Schulz, H. A.

Edgerton:
Cleary, B. L.
Shearer, A. T.
Shearer, F. E.
Shearer, H. A.
Sumner, W. C.

Elcho:
Dailey, P. J.

Eldorado:
Jackson, F. A.

Elkhorn:
Herzog, J. V.
Ridgway, E. T.
Sorenson, E. D.

Ellsworth:
Cannon, C. R.
Nylander, E. G.

Elmwood:
Breed, A. L.

Elroy:
Vogel, C. A.
Vogel, C. C.

Ettrick:
Rogne, C. O.

Evansville:
Guilfoyle, J. P.
Helgesen, E. J.
Smith, C. M., Jr.

Fairchild:
Gibson, H. V.

Fairwater:
Buckland, R. H.

Fall Creek:
Austin, W. T.

Fall River:
Hunt, F. O.

Fennimore:
Bailey, M. A.
Howell, E. C.
Marsden, T. H.

Fond du Lac:
Alexander, W. S.
Borsack, K. K.
Boyd, G. T.
Devine, H. A.
Devine, J. C.
Finn, W. C.
Florin, A. C.
Folsom, W. H.
Gardner, L.
Gavin, S. E.
Helz, J. W.
Layton, O. M.
Leonard, C. W.
Longley, J. R.
McCabe, P. G.
Meiklejohn, D. V.
Mills, R. G.
Rehorst, J. J.
Sharpe, H. R.
Sharpe, J. J.
Simon, L. J.
Smith, E. V.
Twohig, D. J.
Twohig, H. E.
Twohig, J. E.
Waldschmidt, W. J.
Walters, D. N.
Wier, J. S.
Wiley, F. S.
Wojta, W. C.
Yockey, J. C.

Footville:
Harvey, J. R.

Forest Jct.:
Wollersheim, P. J.

Forestville:
Hirschboeck, J. G.

Ft. Atkinson:
Bennett, L. J.
Caswell, H. O.

Chase, Estelle S.
Franzel, J. E.
Gruesen, Frank A.
Majerus, P. J.
Morris, R. C.
Venning, J. R.
Young, Will

Fountain City:
Reinhardt, J. P.

Fox Lake:
Elliott, E. S.

Frederic:
Andrews, W. C.
Arveson, R. G.
Diamond, J. A.

Friendship:
Shapiro, Harry
Treadwell, G. F.

Galesville:
Alvarez, R. L.
Clauson, C. T.
Jegi, H. A.

Genoa City:
Bill, B. J.

Gillett:
Berg, W. R.

Glenbeulah:
Hansen, John

Glenwood City:
McCusker, C. F.
McMahon, A. E.

Glidden:
Gonzalez, L. F.

Grafton:
Balkwill, C. A.

Granton:
Rath, R. R.
Wink, R. H.

Grantsburg:
Johnson, J. E.

Green Bay:
Atkinson, H. S.
Bartran, W. H.
Buchanan, R. C.
Carter, R. M.
Charbonneau, A.
Chloupek, C. J.
Clifford, P. M.
Colignon, J. C.
Comee, William
Cowles, R. L.
Crikelair, F. L.
Decker, W. J.
DeCock, J. L.
DelMarcelle, C. C.
Fuller, M. H.
Gosin, D. F.
Gosin, F. J.
Hendrickson, H.
Icks, Karl
Jordon, E. M.
Kelly, W. W.
Killins, W. A.
Kispert, R. W.
Knox, E. S.
Levitas, I. E.
McCarey, A. J.
Milson, Lewis
Minahan, J. R.
Minahan, P. R.
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Mueller, W. E.
Nadeau, E. G.
O'Brien, E. J.
Oliver, T. J.
Olmsted, A. O.
Quigley, L. D.
Rhode, H. P.
Robb, J. J.
Rose, Felix
Saunders, O. W.
Schmidt, E. S.
Senn, George
Stiennon, O. A.
Tippet, W. P.
Troup, R. L.
Williamson, C. S.
Wolter, H. A.

Green Lake:
Baldwin, G. E.

Gresham:
Vandandaigue, I.

Hales Corners:
Johnson, A. W.
Pierce, D. F.
Wolf, R. C.

Hartford:
Hoffmann, J. G.
Lehmann, F. W.
Loughlin, T. F.
Sachse, F. W.

Hartland:
Bergwall, R. P.
Grover, F. L.
Nixon, H. G. B.

Hawkins:
Baker, J. C.

Hayward:
Ballard, J. A.
Larsen, G. A.

Hazel Green:
Fillbach, H. E.

Highland:
Erickson, M. T.
Trentzsch, M. W.

Hilbert:
Slaney, A. F.
Winkler, R. J.

Hillsboro:
Hansberry, P. H.
MacKechnie, R. S.

Hixton:
Petzke, E. A.

Hollandale:
McDonald, H. F.

Holmen:
Hanson, L. E.

Horicon:
Karsten, J. H.

Hortonville:
Towne, W. H.

Hudson:
Bradford, C. W.
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Livingstone, J. W.
Newton, J. E.

Hustisford:
Goetsch, O. F.
Panetti, P. A.

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Peterson, C. F.
Peterson, D. R.
Stack, G. F.

Iola:
Wilker, W. F.

Iron River:
Johnson, F. G.

Jackson:
Schloemer, A. J.

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Baumgartner, M. M.
Binnewies, F. C.
Clark, W. T.
Cunningham, M. A.
Edden, R. W.
Farnsworth, F. B.
Farnsworth, R. W.
Fifield, G. W.
Hartman, E. C.
Hartman, R. C.
Johnson, W. L.
Klein, Theodore
Koch, V. W.
Kuegle, F. H.
Lapp, H. D.
McGuire, W. H.
Metcalf, G. S.
Moe, H. B.
Munn, W. A.
Neupert, C. N.
Nuzum, T. O.
Nuzum, T. W.
Overton, O. V.
Palmer, W. H.
Pember, A. H.
Snodgrass, T. J.
Stevens, J. V.
Sutherland, F. E.
VanKirk, F. W.
Waufle, G. C.
Welch, F. B.

Jefferson:
Busse, A. A.

Johnson Creek:
Johnston, W. M.

Juda:
Gifford, H. B.

Junction City:
Reis, G. W.

Juneau:
Heath, H. J.
Hebenstreit, A. J.

Kaukauna:
Boyd, C. D.
Flanagan, G. J.
Leigh, Albert

Kendall:
Burke, Mead
Burke, Myra

Kenosha:
Adams, G. F.
Ashley, T. W.
Bennett, W. H.
Bowing, I. E.
Cleary, J. H.
Curtiss, F. D.
Dobbins, Thos.
Gephart, C. H.
Graves, J. P.
Hastings, J. F.
Hill, B. S.
Jorgensen, P. P. M.
Keskey, G. I.
Lane, J. W.
Lipman, W. H.
Mayfield, A. L.
McCarthy, G. W.
McClusky, O. W.
Murphy, S. W.
Pechous, C. E.
Randall, A. J.
Rauch, A. M.
Richards, C. G.
Riordan, J. F.
Ripley, H. M.
Robinson, H. A.
Schlapik, A.
Schwartz, G. J.
Sokow, Theodore
Stewart, W. C.
Swarthout, E. F.
Ulrich, C. F.
Van Westrienen, A.
Windesheim, G.

Kewaskum:
Hausmann, N. E.

Kewaunee:
Dana, D. B.
Dockry, L. E.
Wochos, F. J.
Wochos, W. M.

Kiel:
Knauf, F. P.
Nauth, D. F.

Kimberly:
Maes, C. G.

Kohler:
Cottingham, M. D.
Stein, C. C.

La Crosse:
Anderson, N. P.
Bannen, W. E.
Callahan, J. L.
Carlsson, E. S.
Douglas, F. A.
Eagan, R. L.
Egan, G. J.
Eidam, L. W.
Evans, J. A.
Flynn, R. E.
Gallagher, E. E.
Garrett-Bangsberg, S
Gatterdam, P. C.
Gray, R. H.
Gundersen, A.
Gundersen, A. H.
Gundersen, G.
Gundersen, S. B.
Henke, W. A.
Heraty, J. E.
Houck, M. P.
Jones, W. J.
Krohn, Robert
Lueck, G. W.
MacArthur, D. S.
Mast, B. W.
McGarty, M. A.
McLoone, J. E.
Moran, C. J.
Nimz, Francis N.
Reay, G. D.
Reay, G. R.
Rosholt, J. A.
Simones, V. L.
Sivertson, M.
Skemp, A. A.
Skemp, G. E.
Smith, D. S.
Suiter, F. C.
Swarthout, E. C.
Swarthout, Edyth C.

Townsend, E. H., Jr.
Welsh, S. M.
Wolf, H. E.

Ladysmith:
Lundmark, L. M.
O'Connor, W. F.
Smith, Woodruff

Lake Geneva:
Downs, V. S.
Halsey, R. C.
Jeffers, D. H.
Keenan, T. P.
MacDonald, W. H.

Lake Mills:
Eck, G. E.
Engsberg, W. A.
Leicht, Phillip
Peterson, M. G.

Lancaster:
Doolittle, J. C.
Doolittle, S. W.
Fowler, J. H.
Godfrey, Jos.
Godfrey, R. C.
Kraut, Elgie

Laona:
Clark, J. F. W.
Ovitz, E. G.

Larsen:
Henrichsen, J. A.

La Valle:
Montgomery, R. B.

Lena:
Rose, J. F.

Little Chute:
Doyle, J. H.

Livingston:
Treglown, L. H.

Loganville:
Jewell, E. L.

Lomira:
Kosanke, F. E.

Lone Rock:
Reynolds, Bertha E.

Loyal:
Diamond, F. J.
McGonigal, M.

Luck:
Ries, T. O.

Lugerville:
Rens, J. L.

Luxemburg:
Moraux, Felix

Madison:
Bardeen, C. R.
Blankinship, R. C.
Bleckwenn, W. J.
Boner, A. J.
Bowman, F. F.
Boyce, S. R.
Briggs, S. J.
Brindley, B. I.
Brown, D. A.
Brown, E. J.
Bryan, A. W.
Buerki, R. C.
Bunting, C. H.
Burns, R. E.
Caldwell, Ruth
Calvert, Charlotte
Canan, M. C.
Carns, Marie L.
Carter, H. M.
Chorlog, J. I.
Chorlog, J. K.
Coluccy, M. J. J.
Cook, C. K.
Cooksey, R. T.
Davis, F. A.
Davis, Helen Pratt
Dean, J. P.
Dean, Joseph
Dimond, W. B.
Drischel, F. G.
Ellis, Ivan G.
Elsom, J. C.
Evans, J. S.
Ewell, G. H.
Eyster, J. A. E.
Farnsworth, C. P.
Fauerbach, L.
Fox, Philip
Fox, Philip R.
Gale, J. W.
Ganser, W. J.
Geist, F. D.
Gonce, J. E.
Greeley, H. P.
Greene, H. L.
Guilford, H. M.
Gundersen, C. A. S.
Harkins, J. P.
Harper, C. A.
Harris, J. W.
Head, L. R.
Henika, G. W.
Hurlbut, J. A.
Hyslop, V. B.
Jackson, Arnold
Jackson, J. A., Jr.
Jackson, R. H.
Johnson, H. Curtis
Juster, E. M.
Kay, H. M.
Keck, E. B.
Kundert, F. W.
Kurtz, C. M.
Lee, J. H.
Lindsay, W. T.
Littig, L. V.
Lorenz, W. F.
Lyght, C. E.
Marsh, H. E.
Masten, M. G.
McCormick, S. A.
McGary, Lester
McIntosh, R. L.
Meanwell, W. E.
Meade, F. S.
Middleton, W. S.
Miller, W. J.
Montgomery, R. C.
Mowry, W. A.
Neff, E. E.
Nelson, O. O.
Nesbit, M. E.
Nesbit, W. M.
Newman, Robt.
Paul, Francis
Paul, Lester W.
Pearson, C. R.
Pohle, E. A.
Puestow, K. L.
Purcell, H. E.
Quisling, Sverre
Reese, H. H.
Reineking, W. C.
Ritchie, Gorton
Roach, C. E.
Robbins, G. H.
Robbins, J. H.
Schmidt, E. R.
Schneiders, E. F.
Schubert, C. K.
Sevringhaus, E. L.
Sheldon, W. H.
Sisk, I. R.
Sisk, J. N.
Smedal, A. T.
Smith, K. W.
Sprague, L. V.
Stebbins, G. G.
Stebbins, W. W.
Stovall, W. D.
Sullivan, A. G.
Sullivan, E. S.
Supernaw, J. S.
Taylor, F. B.
Tenney, H. K.
Thornton, M. J.
Tormey, A. R.
Tormey, T. W.
Townsend, E. J.
Van Valzah, R.
Vingom, C. O.
Washburne, Annette C.
Waters, Ralph M.
Wear, J. B.
Weiland, H. P.
Welke, E. G.
Werrell, W. A.
Weston, F. L.
Wheeler, Robert
Winn, H. N.
Wirig, M. H.

Maiden Rock:
Hogan, John

Manawa:
Irvine, R. K.
Irvine, W. J.

Manitowoc:
Aldridge, H. W.
Andrews, M. P.
Barnstein, J. E.
Donohue, W. E.
Gleason, C. M.
Hammond, F. W.
Hammond, R. W.
Hoffman, G. M.
Kemper, W. G.
Luhman, F. S.
MacCollum, C. L. R.
Meany, J. E.
Rees, Thomas H.
Schneck, Nathan
Shimek, A. J.
Steckbauer, J. W.
Stueck, A. F.
Teitgen, Arthur
Tompkins, T. B.
Turgasen, F. E.
Wall, Charles E.

Marathon:
Birnbaum, F. A.

Maribel:
May, J. H.

Marinette:
Axtell, L. E.
Berglund, S. A. B.
Bird, M. D.
Boren, C. H.
Boren, J. W.
Duer, G. R.
Lid, T. A.
May, J. V.
Nadeau, A. T.
Redelings, T. J.
Schroeder, H. F.
Shaw, Robert W.

Marion:
Mulvaney, F. M.
Van Schaick, R. E.

Markesan:
Blewett, M. T.
Pfisterer, F. W.

Marshfield:
Copps, L. A.
Deitchman, M. M.
Doege, K. H.
Doege, K. W.
Doege, P. F.
Hayward, J. C.
Hipke, Wm.
Juers, R. H.
McCormick, G. L.
Milbee, H. H.
Potter, R. P.
Schwarz, S. G.
Sexton, W. G.
Vedder, H. A.
Vedder, J. B.

Mattoon:
Partridge, O. F.

Mauston:
Gregory, A. T.
Hess, J. S., Jr.
Hess, J. S.

Mayville:
Bachhuber, A. E., Jr.
Bachhuber, A. E., Sr.

Mazomanie:
Griswold, F. L.
Schultz, I.

McFarland:
MacLachlan, W. G.

Medford:
Mitchell, F. W.
Nystrum, L. E.
Nystrum, R. C.

Mellen:
Lockhart, C. W.

Menasha:
Corry, F. M.
Forkin, G. E.
Jensen, A. B.

Mendota:
Green, M. K.
Sauthoff, Aug.
Werner, H. C.
Wilkin, T. J.

Menomonee Falls:
Burkhardt, E. W.
Domann, W. G.

Menomonie:
Blosmo, O. J.
Butler, F. E.
Grannis, I. V.
Halgren, J. A.
Heising, A. F.
Long, D. T.
Lumsden, Wm.
Steves, B. J.

Mercer:
Rodecker, R. C.

Merrill:
Austria, W. F.
Bayer, W. H.

Hinckley, H. G.
Kelley, F. L.
Lane, Francis C.
Morris, K. A.
Ravn, Bjarne
Ravn, E. O.
Reinhart, D. B.
Winneman, F. A.

Merrillan:
Lowe, J. W.

Middleton:
Allen, C. F.

Milltown:
Nicholson, J. D.

Milton:
Crosley, G. E.

Milton Junction:
Coon, G. E.
Vogel, Thorn

Milwaukee:
Ackermann, Wm.
Adamkiewicz, J. J.
Allen, L. L.
Altenhofen, A. R.
Altman, M.
Andruszkiewicz, E.
Armbruster, B. F.
Arnold, F. W.
Augur, Alexander
Ausman, D. C.
Aylward, T. J.
Bach, E. C.
Bach, J. A.
Bach, M. J.
Bach, R. J.
Baer, C. A.
Baranowski, S. A.
Bardenwerper, H. E.
Barnes, J. S.
Barta, E. F.
Barth, G. P.
Baugh, C. W.
Baum, E. L.
Baumgart, C. H.
Baumgarten, S.
Baumle, B. J.
Baur, E. F.
Becker, C. J.
Beckman, Harry
Beebe, C. S.
Beffel, J. M., Jr.
Belknap, E. L.
Benton, R. W.
Bentzein, E. W.
Bergen, R. D.
Bernhard, L. A.
Bernhart, E. L.
Bickler, E. P.
Biller, S. E.
Birk, B. J.
Blair, J. F.
Blount, W. P.
Blumenthal, R. W.
Bodden, A. M.
Boerner, R. W.
Boley, M. H.
Bolger, J. Victor
Bork, Albert
Borman, M. C.
Bornstein, Max
Bourne, N. Warren
Brah, A. J.
Brehm, P. A.
Brey, P. F.
Brook, J. J.
Brooks, L. M.
Brown, G. V. I.
Brown, R. C.
Brown, S. V. I.
Bruins, Dirk
Brumbaugh, E. V.
Brunkhorst, R. O.
Bruns, D. H.
Brussock, W. A.
Brzezinski, E. A.
Burbach, T. H.
Burnett, C. H.
Bussewitz, M. A.
Byrnes, M. B.
Caffrey, A. J.
Cahana, S.
Callan, P. L.
Cannon, H. J.
Carey, E. J.
Carhart, G. A.
Carroll, J. H.
Carson, W. J.
Cavaney, J. J.
Chapman, F. M.
Churchill, B. P.
Churchill, Bernard P.
Clarke, T. C.
Coffey, C. J.
Coffey, S. E.
Conroy, C. F.
Cook, E. F.
Cook, Harold E.
Corcoran, C. J.
Craite, E. J.
Crigler, R. R.
Cron, R. S.
Crottier, C. J.
Currer, P. M.
Curtin, A. L.
Curtin, J. G.
Cushing-Lippitt, E.
Dallwig, E. L.
Dallwig, H. C.
Dalton, R. J.
Darling, E. H.
Darling, Frank E., Jr.
Darling, F. E.
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Darling, W. S.
Davelaar, G. W.
Davis, Carl Henry
Dearholt, H. E.
Decker, H. G.
deNeveu, A. V.
De Nosaquo, S.
Dickinson, G. H.
Dieterle, J. O.
Differt, C. C.
Dishmaker, M. C.
Doerr, August
Dorr, A. M.
Drexel, A.
Dries, Joseph
Dundon, J. R.
Durner, U. J.
Eberbach, C. W.
Echols, C. M.
Edelman, Elsa
Egan, W. J.
Eisenberg, J. J.
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Eisenberg, P. J.
Elconin, D. V.
Enzer, Norbert
Epperson, P. S.
Ernst, G. R.
Evans, C. A.
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Everts, E. L.
Farrell, F. R.
Fechter, F. J.
Federspiel, M. N.
Fellman, G. H.
Fernan-Nunez, M.
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(Con. on p. 1054)

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SINUS TROUBLE

Madison, Wis., Oct. 28—"Sinus trouble" is a very old disease that attracts widespread interest because of its new name and new methods of treatment. Many years ago the ache or pain in the forehead and cheeks was considered one of the distressing symptoms of a "common cold." Today these same symptoms are called "sinus troubles." Annually at this season of the year, changes in climate seem to be conducive to the disease among many Wisconsin people. In hot climates, like the American southwest, the disease is practically unknown among native residents.

"Presumably, statistics compiled on the number of cases of sinusitis for the past ten years would show an enormous increase over those of previous decades," declares the Educational Committee of the State Medical Society in a bulletin issued today. "Two reasons account for this: first, the more careful recording and reporting of morbid conditions; second, the fact that unquestionably sinusitis is correctly diagnosed many more times than was true even a short time ago. Two important aids in diagnosing this condition, the x-ray and transillumination, are comparatively recent; more recent still is the great advance in their technique.

"Sinusitis is usually due to infection, directly from the ordinary cold, or from secondary infection of accumulation of mucus in the various sinuses. Two sets of sinuses are most commonly affected; the frontal, lying directly behind the eyebrows, and the maxillary, which are in the cheek bones. If the drainage channels become blocked from congested mucous membrane in the nose, enlarged turbinate bones, or the middle partition of the nose, the mucus is retained in the sinuses and may easily become infected from the nasal bacteria. At times, headache and eye disturbances simulating true sinusitis may be due to pressure from the accumulated secretion.

"In the alternating hot and cold climate of the greater part of the United States, colds are prevalent, large numbers of individuals have faulty nares structurally; for example, high nasal floors, deviated septa, spurs, and enlarged turbinates, many of these due to injuries received during childhood and in sports. Either of these factors, or both, a cold and a faulty nose, account for most of the cases of sinusitis. Theoretically, sinusitis might be avoided if all colds were prevented and all nasal passages free and unobstructed. Practically, that is obviously impossible, so that, in a certain percentage of individuals at least, some sinusitis occurs. Much may be done to prevent sinus complication after a cold has started.

"Acute sinusitis is appropriately treated by shrinking the nasal membranes to facilitate drainage; the use of suction apparatus for the same reason, and often irrigation, where the antrum is involved. These same measures are usually advised in the exacerbations of the chronic type. The persistent use of bland oils in the nose after alkaline gargles is often helpful in alleviating the dropping of mucus into the pharynx. Removal to dry, equable climates frequently result in practical cures as long as the patient remains there; the ailment may return if residence is resumed in the former locality. *To prevent sinusitis;—avoid colds.*"

* * *

THE NO BREAKFAST FAD

Madison, Wis., Nov. 4—"Poor health lurks around the corner for the person who habitually goes without breakfast."

This is the warning issued by the Educational Committee of the State Medical Society of Wisconsin which finds that many girls go without the morning meal in order to keep slender. Practically every city has hundreds of these "underfed" who are starving for thinness.

"The fad of slenderizing has become as great a health problem as diseases," continues the health bulletin. "Efforts at slenderizing must be blamed for the large number of absences from work. The breakfast is an important meal of the day.

"The question as to what constitutes a good breakfast should be determined somewhat by the activity of the individual and the time at which he is to have his next heavy meal. Those who have ample noon meals and are sedentary workers may have very light breakfasts, such as fruit, some kind of bread stuff (toast, rolls or muffins) and a beverage, coffee, cocoa or milk. If the worker takes little food at noon day, breakfast should include fruit, cereal, bread stuff and a beverage at least.

"If one has an active occupation, eggs or occasionally meat, and one other hot dish such as potatoes may be added to the fruit, cereal, bread and beverage menu.

"For the usual mixed family group, where the adults are not very active muscularly, the fruit, cereal, bread and beverage (excluding coffee for children) type of breakfast is most convenient as it provides what the children need as well as what is best for grownups. For one who wishes occasional variety an egg or a serving of bacon may be added without much trouble. As a rule digestion is better when there is one hot dish served at each meal. Sometimes the beverage provides for this.

"To those who are afraid of excess baggage in the form of overweight, we would suggest that the light breakfasts we have outlined are quite necessary. It is more likely that an excess of sugars and starches is the chief cause of a tendency to store fat or that the amount eaten makes a difference. Certain it is that the slenderized figure so much in vogue today does not have the unqualified approval of medical authorities. Marked underweight or overweight are equally foolish and dangerous. One industrial staff physician says that 'the going without breakfast habit is a pernicious one and is apt to lead to very poor health.'"

* * *

DROPSY

Madison, Wis., Nov. 11—While several hundred people in Wisconsin suffer from dropsy, it is not a disease at all but rather a symptom of some other disease. It is one of nature's danger signs which, unless quickly heeded, often results in the development of a disease.

The Educational Committee of the State Medical Society believes that dropsy is one of the most common causes of complaint.

"It is never a primary condition, since it always depends upon some underlying cause," declares the bulletin of the State Medical Society issued today. "The unusual swelling of the extremities, body or face, combined or singly, which passes under the general term of dropsy, depends for its production upon the leakage of the fluid elements of the blood from the vessels. Not only may the visible tissues become water logged in such a process, but the blood serum may leak into any body cavity or tissue.

(Continued on page 1044)

THE JOURNAL BOOK SHELF

Cutaneous X-Ray and Radium Therapy. By Henry H. Hazen, A. M., M. D. Professor of dermatology, Medical Department of Georgetown University; professor of dermatology, Medical Department of Howard University; Member of American Dermatological Association, American Roentgen Ray Society. Illustrated. Price $3.00. C. V. Mosby Co., St. Louis, Mo. 1931.

Bedside Interpretation of Laboratory Findings. By Michael G. Wohl, M. D. Associate Professor of experimental medicine, Temple University Medical School; chief of Metabolic Clinic. Temple University Hospital and chief of the First Medical Diagnostic Clinic, Mt. Sinai Hospital, Philadelphia, Pa. Illustrated. Price $6.00. C. V. Mosby Company, St. Louis, Mo. 1931.

Medical Jurisprudence. By Carl Scheffel, Ph. B., M. D., LL. B. Price $2.50 net. P. Blakiston's Son & Co., Inc., 1012 Walnut St., Philadelphia, Pennsylvania.

Modern Proctology. By Marion C. Pruitt, M. D., L. R. C. P., S. (Ed.), F. R. C. S. (Ed.), F. A. C. S., Atlanta, Ga. Associate in surgery, Emory University School of Medicine; assistant visiting surgeon, Grady Hospital; Proctologist, Crawford W. Long Memorial Hospital, and Clinic, Georgia Baptist Hospital, and Anti-Tuberculosis Association. With 233 illustrations. Price $8.00. C. V. Mosby Company, St. Louis, Mo. 1931.

The Letters of Dr. Betterman. By Charles Elton Blanchard, M. D. Medical Success Press, 36 N. Phelps St., Youngstown, Ohio. 156 pages, price $1.00.

Collected Papers of the Mayo Clinic and the Mayo Foundation. Volume XXII. Edited by Mrs. Maud H. Mellish Wilson, Richard M. Hewitt, B. A., M. A., M. D., and Mildred A. Felker, B. A. Octavo volume of 1125 pages with 234 illustrations. Philadelphia and London: W. B. Saunders Company, 1931. Cloth, $13.00 net.

Simple Lessons in Human Anatomy. By C. H. Harvey, M. D., professor of anatomy, University of Chicago. Illustrated. American Medical Association, Chicago.

Accidental Injuries. The Medico-Legal Aspects of Workmen's Compensation and Public Liability. By Henry H. Kessler, A. B., M. D., F. A. C. S.

The Practice of Medicine. By A. Stevens, A. M., M. D., professor of applied therapeutics in the University of Pennsylvania; visiting physician to Philadelphia General and University Hospitals; consulting physician to St. Agnes' Hospital, Philadelphia. Third edition, entirely reset. 1150 pages, illustrated. Philadelphia and London, W. B. Saunders Company, 1931. Cloth $8.00 net.

Clinical Laboratory Methods. By Clyde L. Cummer, Ph. B., M. D., F. A. C. P., formerly associate clinical professor of clinical pathology. School of Medicine, Western Reserve University, Cleveland; instructor in dermatology and syphilology, School of Medicine, Western Reserve University, visiting dermatologist, Charity and St. Alexis Hospitals, Cleveland. Third edition, thoroughly revised. Illustrated. Price $6.75. Lea & Febiger, Philadelphia, 1931.

Gonorrhea in the Male and Female. By Percy S. Pelouse, M. D., associate in urology and assistant genito-urinary surgeon at the University of Pennsylvania; fellow of the Philadelphia College of Physicians, Philadelphia. Second edition, revised. 440 pages with 92 illustrations. W. B. Saunders Company, Philadelphia and London. Cloth $5.50 net. 1931.

BOOK RECEIVED FOR REVIEW

Infections of the Kidney. By Meredith F. Campbell, M. D., F. A. C. S. Price $3.00. Harper & Brothers Publishers, 49 East 33rd St., New York, N. Y.

Surgical Pathology of the Skin, Fascia, Muscles, Tendons, Blood and Lymph Vessels. By Arthur E. Hertzler, M. D., surgeon to the Agnes Hertzler Memorial Hospital, Halstead, Kansas, professor of surgery, University of Kansas. 260 illustrations. J. B. Lippincott Company, Philadelphia.

An Introduction to the Literature of Vertebrate Zoology. Compiled and Edited by Casey A. Wood, M. D., LL. D., Collaborator, Division of Birds, Smithsonian Institution. Oxford University Press, London, 1931.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, 424 N. Charter Street, Madison, Wis.

Diseases of the Thyroid Gland. By Arthur E. Hertzler, M. D., surgeon to the Halstead Hospital, With a chapter on Hospital Management of Goiter Patients by Victor E. Chesky, M. D., associate surgeon to Halstead Hospital. Second edition, entirely rewritten. Cloth $7.50. C. V. Mosby Company, St. Louis, 1929.

The preface to the second edition is very appropriate, and explains the book very well. It is apparent that the author draws his information almost entirely from his own wide experience and that he attempts to present a short resumé of this information.

The chapter on Pathological Anatomy is the best and fulfills Dr. Hertzler's wish that "the chief interest will center on the views of the pathology of the thyroid gland." The author explains that he has deliberately omitted discussion on the question of Lugol's solution because this subject has been fully covered in a previous article. The writer "designedly avoided" presentation of statistics in his first edition and suggested that his experiences might not agree with those of other institutions. The second edition offers very little additional information. The chapter on "goiters in unusual places" is too lengthy when compared with the scant discussion of more important subjects. The book is written in the author's characteristic manner and offers some practical information. I. S.

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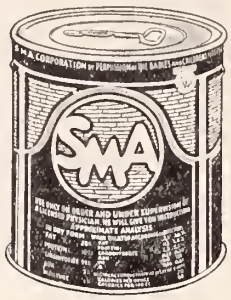

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Surgical Pathology of the Genito-Urinary Organs. By Arthur E. Hertzler, M. D., surgeon to the Agnes Hertzler Memorial Hospital, Halstead, Kansas; professor of surgery, University of Kansas. 222 illustrations. J. B. Lippincott Company, Philadelphia.

This monograph is divided into three parts. Part I deals with diseases of the external genitalia in the male. Part II with the diseases of the prostate and bladder. Part III with the diseases of the kidneys and ureters.

In the preface the author states that he has "sought to present the subject from the viewpoint of the general surgeon, freed as much as possible from the complications of the specialist." One has to read but a few pages of the text to appreciate how admirably this has been attained. From page 1 to page 277 one is not only aware of the fact that he is reading a general surgeon's view of the specialty, but he feels that the author has not familiarized himself with the modern scientific investigation bearing upon the subject which he discusses. Individual views are insufficiently supported to be accepted. Practitioners and students can gain a better knowledge of the surgical pathology of the diseases of the genito-urinary organs from any standard text book on urology. I. R. S.

Approved Laboratory Technic. Prepared under the auspices of The American Society of Clinical Pathologists by John A. Kolmer, M. D., Dr. P. H., professor of pathology and bacteriology, Graduate School of Medicine, University of Pennsylvania; professor of immunology and chemotherapy, School of Medicine, Temple University; head of Department of Pathology and Bacteriology, Research Institute of Cutaneous Medicine; and Fred. Boerner, V. M. D., associate professor of Bacteriology, Graduate School of Medicine, University of Pennsylvania. With 11 colored plates and 300 illustrations. D. Appleton & Company, New York. 1931.

This book is a manual of laboratory methods. It is devoted entirely to the description of technique. Clinical pathology is not discussed. It is, therefore, not a text of clinical pathology.

Until very recently, text books of clinical pathology have neglected the newer sciences of bacteriology and immunology. Most of them also fail to emphasize the importance of clinical data for the interpretation of laboratory results. Methods of collecting specimens, which after all determine the value of the results of the examination of these specimens, are rarely mentioned. For these reasons and others, clinical laboratory practice is not considered to be part of clinical medicine. The ward clinician, who uses the stethoscope and fleximeter, is not considered a technician. The laboratory clinician, however, who uses the microscope, test tube, and platinum loop, is looked upon as a pure technician. This has brought about a depreciation of laboratory methods and has resulted in this important field of medical technology being practiced largely by non-medical graduates, usually young women of high school education or better. This book, unfortunately, emphasizes this erroneous relation of these two branches of medical practice because it emphasizes technique to the complete neglect of clinical diagnosis.

The authors have brought together into one text techniques that are used in various sciences which are applicable to medical diagnosis and sanitary surveys. These technical methods have heretofore been scattered through the text books of the various sciences. For that reason it will be found useful to clinical pathologists as a reference book. The medical student in courses of clinical pathology will find it advantageous when used in connection with a text which discusses clinical diagnosis or in conjunction with adequate lectures on the clinical application of laboratory methods. The physician who is not doing his own laboratory work will get no assistance from it.

There is no criticism of what the book contains. The technique described is in use in all well conducted laboratories. The criticism is the absence of important clinical discussion in a book which deals with the technique so important to medical diagnosis. A companion volume, dealing with clinical laboratory diagnosis, would make a complete work and is to be hoped for. W. D. S.

PRESS SERVICE

(Continued from page 1041)

"A number of factors enter the production of dropsy, or oedema as it is technically termed. The simplest of these to understand is the mechanical obstruction to the return blood or lymph, whereupon the fluid elements of the blood are lost through the walls of the blood vessels or lymphatics, causing dropsy in the part normally drained by these blocked or obstructed channels. Where the circulation is deficient by reason of poor pumping force on the part of the heart, dropsy develops in the parts most remote from the heart, namely the feet at night when the subject has been up and about all day. Where the insufficiency of the heart is of a mild order this swelling of the feet will disappear by morning, only to recur after the patient is about all day. As the heart becomes weaker such a dropsy advances until the thighs, trunks and eventually the factors enter into the question of the development of dropsy with the retention of salt and the disturbance of certain of the other chemical constituents of the body. Dropsy from Bright's Disease usually develops first about the eyes and face and is accompanied by a peculiar waxy pallor; eventually dropsy of this kind may likewise become general. In the severe anemias, dropsy occurs in dependent and unexpected portions of the body and is determined by the too fluid state of the blood, although many other elements enter into the question. It is obviously true that such patients will have increased permeability of the capillaries because of the impoverished condition of the blood and hence a greater chance for the leaking of serum from these small blood vessels. One of the most interesting groups of patients suffering from dropsy are those in whom a food deficiency is the explanation. During the World War great numbers of individuals in the Central Empires suffered from the so-called war oedema; and contrary to the conclusion that time which blamed this condition upon vitamine deficiency, it has been proved to depend upon a deficiency of proteid.

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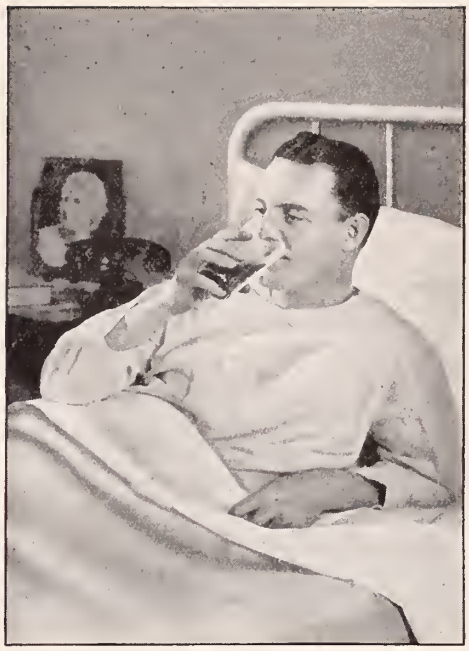

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"Because of the common factors entering into the production of dropsy and the many underlying causes, it is highly important for the layman to submit his particular complaint for careful scrutiny; so that first of all the cause may be recognized, and then that the appropriate measures may be applied for its control."

* * *

REGULARITY IN MEALS

Madison, Wis., Nov. 19—That improved health will come to children who have regular meals has been demonstrated by hot lunches in Wisconsin's rural schools. About 2,572 rural schools in Wisconsin furnish hot lunches to their children and the Educational Committee of the State Medical Society believes that this is one of the factors which has improved health conditions throughout rural communities in the past five years.

At the suggestion of the home economics department of the University of Wisconsin the plan for hot lunches in rural schools was launched in cooperation with the teachers, health and medical organizations. In a bulletin this week the State Medical Society indicates that an extension of this service to all the schools of the state would be beneficial.

"Nearly all modern rural schoolhouses are now equipped with facilities for cooking and serving hot lunches to the pupils. This same equipment is also utilized for community gatherings," declares the bulletin issued today.

"Experience has shown that it is not advisable to attempt elaborate service in connection with these hot lunches and the present trend is towards simplification of the whole process. At the present time emphasis is being placed on the serving of one hot dish. Mothers are asked to send a pint jar of prepared food which can readily be reheated at the schoolhouse, the only equipment required being a receptacle for reheating the food before serving. Nearly all schools are provided with an oil stove or an electric plate. The food cans are suitably labeled so that each pupil gets the food prepared at his home. All kinds of vegetables and soups readily lend themselves to this process of reheating. Hot cocoa is used frequently in connection with these noontime lunches.

"The plan of serving a hot dish for the children's noontime meal has greatly changed the manner of eating at schoolhouses. Frequently the children unite around a common table and utilize the period in more or less formal conversation or in the discussion of current events and other suitable topics of conversation. Incidentally, food values are taught as well as information relative to the proper balance of foods. The value of milk in the child's diet is also emphasized. Many mothers see to it that extra food is sent so that any undernourished children in the community may receive liberal portions without any suggestion of charity being involved.

"The custom of serving a hot lunch fits in well with the teacher's plans for a supervised play hour as well as resulting in better habits of eating on the part of the children and a more balanced diet which results in wholesome growth and development on the part of the children. It is hoped that the plan will continue to be extended through the coming season particularly to the end that children from impoverished families may continue to partake of a well rounded diet."

* * *

COMMUNICABLE DISEASES

Madison, Wis., Nov. 27—Decrease of deaths from communicable diseases is one of the outstanding accomplishments for which the people of Wisconsin can be thankful, according to the State Medical Society in an official bulletin issued today. The bulletin points out that a sudden drop in many diseases which heretofore ravished communities was one of the greatest boons to society.

In a carefully prepared statement issued by the Educational Committee of the State Medical Society today, it declares that there have been declines in Tuberculosis, Typhoid Fever, Diphtheria, Small Pox, and Measles, as well as decrease in deaths from Drownings, and Violence within the past year.

"Statistics compiled from the official records of the Bureau of Vital Statistics of the State Board of Health show that during the first six months of 1931, there were only 3 cases of typhoid fever as compared with 25 cases during the year 1930," declares the Bulletin issued today. "For the same six months there were 31 cases of diphtheria compared with 72 for the entire year of 1930.

"In the years gone by, especially in pioneer times, small pox ravished the state. Vaccination, however, has driven out the disease until during the first six months of 1931 there was not a single case of small pox. This was an outstanding achievement and one for which the people of Wisconsin can be thankful. The record can be maintained by public cooperation.

"For the first six months of 1931 there were 37 cases of measles compared with 99 for 1930. There were 83 drownings in the first six months of 1931 compared with 239 for the entire year of 1930.

"Even auto accidents have declined in percentages. There were 316 deaths from automobile accidents during the first half of 1931 compared with 815 for the year 1930.

"These statistics show savings of hundreds of lives as a result of care and caution in preventing diseases.

"The saving of human lives is one of the outstanding things for which Wisconsin can be thankful and the record for the past six months shows how well this is being achieved and how thankful the entire state should be today."

Recent Licentiates in Wisconsin

BY EXAMINATION

Name	School of Graduation	Year	Present Address
Andre, Edgar F.	Marquette Medical School	1931	2850—3rd Ave., Kenosha, Wis.
Babbitz, Albert L.	Marquette Medical School	1931	2624 N. 53rd St., Milwaukee, Wis.
Bachhuber, Francis G.	Northwestern Medical School	1931	306 Williams St., Mayville, Wis.
Barnes, Harry A.	U. of Wis. Medical School	1930	2200 Kilbourn Ave., Milwaukee, Wis.
Bender, Boris I.	Marquette Medical School	1931	2476 N. Grant Blvd., Milwaukee, Wis.
Benjamin, Hyman B.	Marquette Medical School	1931	346—68th St., Wauwatosa, Wis.
Brennan, Francis J.	Marquette Medical School	1931	115 Evans St., Oshkosh, Wis.
Brusky, Alvin Henry	Marquette Medical School	1931	2400 Wis. Ave., Milwaukee, Wis.

"Loose Talk"

There has been much commendable criticism, of late, in professional publications and elsewhere, of "loose talk" by physicians and dentists as a principal cause of the marked increase in malpractice litigation — particularly where the "mass-selling" plan of professional protection has been called to account.

The emphasis placed on the dangers of "professional" loose talk, however, serves to reveal the advantage of likewise eliminating the discussion of alleged professional errors (or malpractice claims and suits resulting from them) by large armies of insurance agents — particularly those handling multiple lines and contacting the laity as well as the professions. Loose talk is not always confined within the professional ranks.

The Medical Protective Company enjoys a unique position. It employs specially trained representatives, writing professional protection exclusively. It teaches respect for the professional ethics of its patrons. It considers its relations with its clients inviolate. It stresses the importance of keeping the insurance feature in the background — the danger of parading insurance before damage-suit lawyers and juries. It operates with noteworthy success, as a secret but powerful ally to the Doctor in trouble.

Recent developments in the general malpractice situation serve to emphasize the advantages to the professions of supporting a Company which understands professional problems, respects professional ethics, and, withal, safeguards the professional purse.

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*Address*_____

City_____

11-31

Name	School of Graduation	Year	Present Address
Buckley, Roland A.	Marquette Medical School	1931	Mil. Co. Hosp., Wauwatosa, Wis.
Chesky, George H.	Marquette Medical School	1931	S. 44th St. and W. Morgan Ave., Milwaukee, Wis.
Cole, Llewellyn R.	U. of Wis. Medical School	1930	2962 N. Prospect Ave., Milwaukee, Wis.
Cummings, Earl F.	U. of Wis. Medical School	1930	615 State St., Madison, Wis.
Dettmann, Norbert F.	Marquette Medical School	1931	2404 Aver Ave., W. Milwaukee, Wis.
Dickelmann, Lorin E.	Marquette Medical School	1931	730—2nd St., Milwaukee, Wis.
Doeringsfeld, Hilton L.	Loyola Medical School	1930	Fennimore, Wis.
Dunker, George O.	Marquette Medical School	1931	Mil. Co. Hospital, Wauwatosa, Wis.
Dunn, Cornelius Francis	Marquette Medical School	1931	Mil. Co. Hospital, Wauwatosa, Wis.
Eisenberg, Edward	Marquette Medical School	1931	1604 W. Lloyd St., Milwaukee, Wis.
Fein, Norman N.	U. of Wis. Medical School	1930	Mil. Co. Hospital, Wauwatosa, Wis.
Fox, Meyer Simon	Northwestern Medical School	1931	% Mt. Sinai Hospital, Milwaukee, Wis.
Frechette, Francis M.	U. of Wis. Medical School	1930	6th St., South Wisconsin Rapids, Wis.
Friske, Oscar Walter	U. of Wis. Medical School	1930	R. F. D. #1, Box 138, Sparta, Wis.
Goldberg, Nathan	Marquette Medical School	1931	2512 N. 50th St., Milwaukee, Wis.
Goodsitt, Edward	Marquette Medical School	1931	1557—N. 47th St., Milwaukee, Wis.
Greenberg, Abraham I.	Marquette Medical School	1931	1513 W. Galena St., Milwaukee, Wis.
Hardgrove, Thomas M.	Marquette Medical School	1931	Eden, Wis.
Icks, Karl R.	U. of Wis. Medical School	1930	735 Jackson St., Green Bay, Wis.
James, Lawrence J.	Marquette Medical School	1931	3206 W. Clybourn St., Milwaukee, Wis.
Jensen, Johannes M. L.	Marquette Medical School	1931	% Dr. N. Hjortvad, Brabrand, Denmark, Europe
Jurss, Charles Darwin	Marquette Medical School	1931	1354 N. 32nd St., Milwaukee, Wis.
Kaske, Gordon John	U. of Wis. Medical School	1930	East Troy, Wis.
Kilkenny, George S.	Marquette Medical School	1931	Mil. Co. Hospital, Wauwatosa, Wis.
Kleinpell, Walter C.	U. of Wis. Medical School	1930	Cassville, Wis.
Krehl, Wm. Homer	U. of Wis. Medical School	1930	408 E. Wilson, Madison, Wis.
Kreul, Randolph W.	St. Louis U. Medical School	1930	928 Park Ave., Racine, Wis.
Kronzer, Joseph John	Marquette Medical School	1931	330 Merritt Ave., Oshkosh, Wis.
Kruszewski, Joseph L.	Marquette Medical School	1931	1902 Ash St., Erie, Pa.
Kult, Anthony J.	Marquette Medical School	1931	1501 W. Cherry St., Milwaukee, Wis.
Lavine, Israel H.	U. of Wis. Medical School	1930	324 John Ave., Superior, Wis.
Lemmer, Kenneth E.	U. of Wis. Medical School	1930	421 High Ave., Spooner, Wis.
Loeber, Arthur Wm.	Marquette Medical School	1931	1727 So. 29th St., Milwaukee, Wis.
Breitzman, Thomas R.	Kirksville College of Osteopathy	1931	Comm. Nat'l Bank Bldg., Fond du Lac, Wis.
Margoles, Maxon E.	U. of Wis. Medical School	1930	2642 N. 50th St., Milwaukee,
Mastrobuono, Amedeo	Marquette Medical School	1931	804 N. 25th St., Milwaukee, Wis.
Matros, Nat Hamilton	Marquette Medical School	1931	1817 N. 9th St., Milwaukee, Wis.
McElligott, Joseph A.	Marquette Medical School	1931	937 N. 17th St., Milwaukee, Wis.
McNamara, Louis V.	Marquette Medical School	1931	Mil. Co. Hosp., Wauwatosa,
Mortensen, Otto Axel	U. of Wis. Medical School	1930	405 Science Hall, Madison, Wis.
Moxon, Gail Fitch	Marquette Medical School	1931	3061 N. Hackett Ave., Milwaukee, Wis.
Pescor, Micheal J.	U. of Wis. Medical School	1930	St. Elizabeth's Hosp., Washington, D. C.
Peters, Leo Michael	Marquette Medical School	1931	199 E. Wisconsin Ave., Fond du Lac, Wis.

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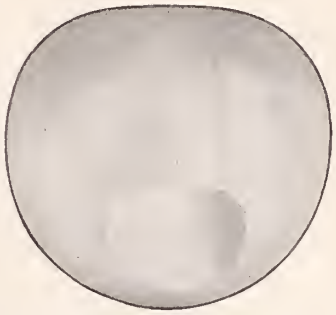

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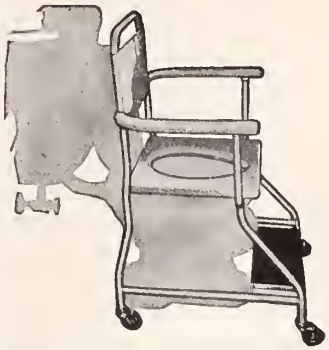

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Name	School of Graduation	Year	Present Address
Primakow, Max J.	Marquette Medical School	1931	2112 N. 17th St., Milwaukee, Wis.
Ptashkin, Edw. H.	Marquette Medical School	1931	2211 N. 9th St., Milwaukee, Wis.
Purtell, Rob't F.	Marquette Medical School	1931	Mil. Co. Hosp., Wauwatosa, Wis.
Quisling, Abraham A.	U. of Wis. Medical School	1930	421 Patterson St., Madison, Wis.
Rank, Ralph Theo.	Marquette Medical School	1931	2845 W. Highland Ave., Milwaukee, Wis.
Rice, Erwin Leo	Marquette Medical School	1931	2968—N. 48th St., Milwaukee, Wis.
Risteen, Wilford Arliss	U. of Wis. Medical School	1930	Wis. Gen. Hosp., Madison, Wis.
Rosenthal, Sam	Marquette Medical School	1931	2702 McKinley Blvd., Milwaukee, Wis.
Rothenmaier, Glenway L.	Marquette Medical School	1931	2220 N. 35th St., Milwaukee, Wis.
Schmidt, Albert C.	U. of Neb. Medical School	1930	3321 N. Maryland Ave., Milwaukee, Wis.
Schneider, Clifford R.	Marquette Medical School	1931	2802 S. Herman St., Milwaukee, Wis.
Schultz, Isadore	U. of Wis. Medical School	1930	1 N. Blair St., Madison, Wis.
Schulz, Gordon John	Marquette Medical School	1931	2928 N. 55th St., Milwaukee, Wis.
Schumacher, Hyman Saul	Marquette Medical School	1931	2742 Teutonia, Milwaukee, Wis.
Schwade, Edward David	Marquette Medical School	1931	Mil. Co. Hosp., Wauwatosa, Wis.
Shallow, Bernard H.	Marquette Medical School	1931	653—78th Ave., West Allis, Wis.
Tuft, Warren R.	U. of Wis. Medical School	1930	St. Francis Hosp., La Crosse, Wis.
Van Valin, Erwin C.	Marquette Medical School	1931	Lake Beulah, Wis.
Van Zanten, Wesley Wm.	Marquette Medical School	1931	2222 Lake Shore Drive, Sheboygan, Wis.
Stevenson, Stuart P.	Chicago College of Osteopathy	1931	% Dr. Gerald Kent, Kent, Ohio
Vogel, Henry Louis	Marquette Medical School	1931	801 Milwaukee Ave., South Milwaukee, Wis.
Wagner, Alphonse J.	Marquette Medical School	1931	Mil. Co. Hosp., Wauwatosa, Wis.
Waxman, Saul I.	Marquette Medical School	1931	508 Vine St.. Milwaukee, Wis.
Weissmiller, Lester Lee	U. of Wis. Medical School	1930	217 N. Orchard St., Madison, Wis.
Wiesen, Raymond Paul	Marquette Medical School	1931	2517 W. Vine St., Milwaukee, Wis.
Williams, David Leslie	U. of Wis. Medical School	1930	325 W. Main St., Madison, Wis.
Williams, Earl B.	Marquette Medical School	1931	Shiocton, Wis.
Wirka, Herman W.	U. of Wis. Medical School	1930	Wis. Gen. Hospital, Madison, Wis.
Wiswell, Clifford Y.	U. of Wis. Medical School	1930	Elkhorn, Wis.
Zaun, John Jos. Jr.	Marquette Medical School	1931	3111 W. Juneau Ave., Milwaukee, Wis.
Baeumle, Clarence E.	Rush Medical College	1929	127 N. Clinton St., Chicago, Illinois
Bear, Nathan E.	Northwestern Medical School	1931	411 Garfield Ave., Chicago, Illinois
Burpee, George F.	Washington U. School of Medicine	1929	314 St. Lawrence Ave., Janesville, Wis.
Beebe, DeWitt C.	U. of Nebraska Medical School	1930	Sparta, Wis.
Carlson, Verne Wm.	U. of Minnesota Medical School	1931	Lake Mills, Wis.
English, Leo V. (Col.)	Northwestern Med. School	1916	448 Indiana Ave., Toledo, Ohio
Eurit, Deering H.	U. of Indiana Medical School	1921	Otterbin, Indiana
Evans, Albert E.	U. of Wis. Medical School	1929	917 Grand Ave., Racine, Wis.
Fox, George Wm.	Rush Medical College	1931	2418 E. Kennelworth Pl., Milwaukee, Wis.
Fredrickson, Adolph R.	St. Louis U. School of Medicine	1920	Lansing, Iowa
Garding, Clarence J.	Creighton Medical School	1927	Conception Jct., Mo.
Graber, Rex E.	Rush Medical School	1924	1509—3rd Ave. So., Fargo, North Dakota
Henderson, Raymond J.	Northwestern Medical School	1930	Shawano, Wis.

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed care Wisconsin Medical Journal.

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WANTED—To correspond with physician who expects to do postgraduate work in eye, ear, nose, and throat, in Europe this coming winter and spring. Address Number 855 in care of The Journal. ND

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WANTED—Copies of November, 1931, issue of the Wisconsin Medical Journal. Will pay 50 cents for each copy received. Wisconsin Medical Journal, 119 E. Washington Ave., Madison.

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PHYSICIAN WANTED—Leaving good location in south central Wisconsin. Want good physician to take over my practice. Very small investment. No initial cash payment necessary. Write Number 858 in care of the Journal. NDJ

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Name	School of Graduation	Year	Present Address
Hoel, Kenneth Paul	U. of Wis. Medical School	1929	Cottage Grove, Wis.
Houchins, Edward K.	Chicago Col. of M. & S.	1916	Milwaukee Sanitarium, Wauwatosa, Wis.
Jorris, Edwin Hall	U. of Minnesota Medical School	1930	Excelsior, Wis.
Larson, Adolph J.	U. of Illinois Medical School	1929	Volga, Iowa
McCormack, Edw.	Loyola Medical School	1930	228 Florida St., Larium, Mich,
Meier, Wm. G. Jr.	U. of Michigan Medical School	1929	813 St. Claire Ave., Sheboygan, Wis.
Morton, Silvanus A.	U. of Dalhousie (Can.)	1926	Mayo Clinic, Rochester, Minn.
Moss, John George	U. of Minnesota Medical School	1930	641, Grand Ave., St. Paul, Minn.
Olson, Clifford A.	U. of Minnesota Medical School	1931	2508—33rd Ave., So. St. Paul, Minn.
Rakauskas, Anthony G.	Northwestern Medical School	1930	2415 W. Marquette Rd., Chicago, Ill.
Rasmussen, Hugh A.	U. of Illinois Medical School	1930	Westby, Wis.
Salzman, Jay Marvin	Washington U. School of Medicine	1929	1105—Sixteenth St., Racine, Wis.
Sanders, Russell F.	Indiana Medical School	1930	Hogerstown, Ind.
Smedal, Agnar T.	Rush Medical School	1929	1345 Morrison St., Madison, Wis.
Smith, Eugene C.	U. of Michigan Medical School	1928	Lutheran Hospital, La Crosse, Wis.
Springberg, Joseph C.	U. of Wis. Medical School	1930	1111 Spring St., Madison, Wis.
Thornton, John W.	Rush Medical School	1915	Lansing, Iowa
Torres, Lois W.	U. of Michigan Medical School	1929	Milton, Wis.
Townsend, DeWayne	U. of Harvard Medical School	1915	% Dr. Connor, Appleton, Wis.
Walter, George W.	Northwestern Medical School	1931	1356 Washington Ave., Racine, Wis.
Maloney, Frank G. H.	U. of Toronto Medical School	1924	Ironwood, Mich.
Miles, John W.	Northwestern Medical School	1930	Lansing, Iowa
Newcomb, Kate P.	U. of Buffalo Medical School	1917	Boulder Jct., Wis.
Tegge, Charles Wm.	Northwestern Medical School	1929	313 Burton Ave., Waukegan, Ill.
Weiss, Leo Henrich	U. of Munich, Germany	1922	204 Monona Ave., Madison, Wis.
Dorchester, Daniel E.	Northwestern Medical School	1930	Sturgeon Bay, Wis.
Gummerman, George J.	Marquette Medical School	1931	2412 E. Bradford Ave., Milwaukee, Wis.
Martin, Richard E.	Marquette Medical School	1931	1330 N. 26th St., Milwaukee, Wis.
McCarty, Robert T.	Marquette Medical School	1931	223 Brothers St., Kaukauna, Wis.
Swanton, Milo Earl	Marquette Medical School	1931	5915—31st Ave., Kenosha, Wis.
Tessier, Alban F.	U. of Wis. Medical School	1929	Columbia Hospital, Milwaukee, Wis.
Thill, George E.	Marquette Medical School	1931	2511 N. 49th St., Milwaukee, Wis.
Watson, Eldon Levings	U. of Wis. Medical School	1930	General Delivery, Columbus, Wis.

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Name	School of Graduation	Reciprocating From	Present Address
Aageson, Carl W.	U. of Iowa Medical School 1930	Iowa	925 Mound St., Madison, Wis
Averbook, Marvin S.	U. of Mich. Medical School 1930	Michigan	1106 Hammond Ave., Superior, Wis.
Backus, Otto August	U. of Wis. Medical School 1929	Oklahoma	539 N. 31st St., Milwaukee, Wis.
Broberg, Gail R.	U. of Mich. Medical School 1929	Michigan	Blue Earth, Minn.
Cantwell, Arthur A.	Northwestern Medical School 1931	Illinois	Shawano, Wis.
Cowan, Abe	U. of Ohio Medical School 1925	Ohio	Milwaukee Children's Hosp., Milwaukee, Wis.
Cronk, Charles F.	U. of Minn. Medical School 1931	Minnesota	Cameron, Wis.
Dryer, Raymond B.	U. of Mich. Medical School 1925	Michigan	Morrisonville, Wis.
Dunlap, Claude M.	U. of W. Va. Medical School 1930	Ohio	Box H., Winnebago, Wis.
Exley, Erwin W.	U. of Minn. Medical School 1925	Minnesota	305 E. Walnut St., Green Bay, Wis.
Fain, Samuel Clark	U. of Tenn. Medical School 1929	Tennessee	% The Spa, Waukesha, Wis.

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Gebhard, Urban E.	Northwestern Medical School 1931	Illinois	3515 N. Hackett Ave., Milwaukee, Wis.
Hockett, Asahel J.	U. of Oregon Medical School 1929	Oregon	Wis. Gen. Hosp., Madison, Wis.
Holcombe, Rob't L.	Rush Medical School 1926	Illinois	Marine, Illinois
Jurgens, George H.	U. of Iowa Medical School 1928	Iowa	Muirdale San., Wauwatosa, Wis.
Keeley, John L.	Loyola Medical School 1930	Illinois	Wis. Gen. Hosp., Madison, Wis.
Kuehn, Alvin E.	U. of Iowa Medical School 1930	Iowa	Viroqua, Wis.
Macklin, Wm. Edward, Jr.	U. of Minn. Medical School 1930	Minnesota	Litchfield, Minn.
Marsden, Wendall H.	U. of Wis. Medical School 1927	Illinois	411 Garfield Ave., Chicago, Ill.
Meier, Harold Joseph	U. of Mich. Medical School 1929	Michigan	668 Liberty St., Burlington, Wis.
Miller, Russell E.	U. of Indiana Medical School 1930	Indiana	Burlington, Wis.
Prefontaine, Kenneth F.	Loyola Medical School 1931	U. S. Navy	Slinger, Wis.
Schellhouse, Earl M.	Marquette Medical School 1929	Indiana	2102 Hanna St., Ft. Wayne, Ind.
Singer, Harold Douglas	U. of London, England	Nebraska	30 N. Michigan Ave., Chicago, Ill.
Thompson, Rob't C.	U. of Minn. Medical School 1930	Minnesota	Cumberland, Wis.
Townsend, Russell B.	U. of Mich. Medical School 1926	Michigan	421 So. Church St., Prairie du Chien, Wis.
Welsh, Sylvester M.	U. of Iowa Medical School 1929	Iowa	401 Main St., La Crosse, Wis.

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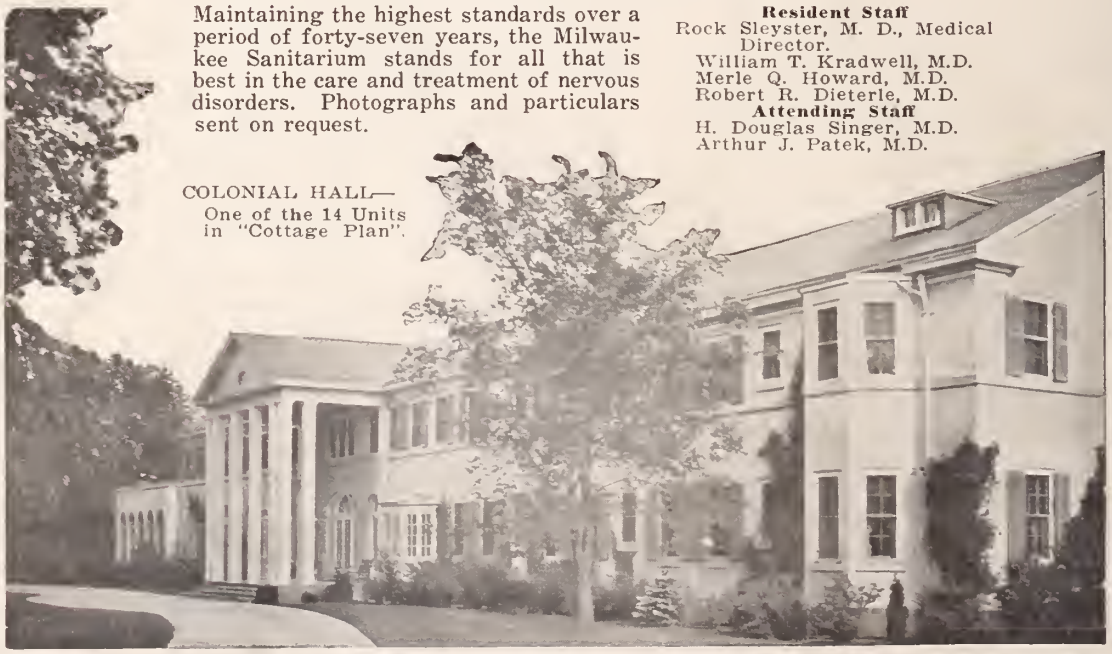

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